The President: Good evening everybody. This evening we have got a very important lecture and I am glad to see you have all come. Matt Griffiths is a Professor of Nurse Prescribing, or a visiting Professor. More substantially, he is a Senior Nurse with a long background in nursing, particularly in Accident and Emergency medicine, but most importantly from our point of view he is the Advisor to the RCN about Nurse Prescribing. This is an absolutely vital subject, which reflects what is happening to medicine in this country and has happened over the last ten years. Ten years ago nurse prescribing was virtually unknown; prescribing was regarded as being a monopoly of the medical profession. It was one of the few privileges which they had and it was so described as “a privilege” of the medical profession as a result of being registered under the Medical Act. Now the number of drugs which nurses cannot prescribe is confined to an extremely short list. Some people have likened the effects of this to the end of civilisation as we know it. Others have noticed that the end of civilisation seems to take other forms and has other causes. It may be a reflection of the fact that people who are nurses now are different in background and education and qualification and preparation for their job than they were ten years ago and the expectation of society hasn’t been party to it. Matt is going to talk to us about that. He is going to tell us fundamentally what nurses do prescribe and how it has changed and how it is now regulated and talk to us about the advantages and disadvantages. So it is with great pleasure that I introduce Matt Griffiths to come and talk to us. (Applause)

Professor Griffiths: Good evening. Thanks very much for inviting me to speak. What I am going to do this evening is to go through some of the background of nurse prescribing, some of the history, where we are today, and also some background into some research that has actually shown what we are doing now in terms of practice. Whenever I do any public speaking I always look to my public speaking guru, a man called George W Bush. He once said: “I hope you leave here and walk out and say ‘What did he say?’” Well, I hope that you walk out of here this evening and understand a little bit more about what is going on in terms of prescribing and medicines management in the nursing profession.

So tonight we will go through “What ‘prescriber’?” – and I have put “prescriber” in inverted commas because they are not all methods of prescribing – I will then go into the issue of prescribing, how it came about, and the current situation in terms of what is actually going on in practice and how different methods of training are used for prescribers, different methods of prescribing medicines and finally, some updates on controlled drugs. I have been lucky enough to be involved in the Shipman Inquiry and the subsequent work to the Shipman working groups for the last four years, and it is continuing even now. We have got another 18 months of work ahead to actually put in place some of the Shipman recommendations. I will also be going into education, entrepreneurs, nurse entrepreneurs! – what a frightening thought – and then, as I said, some research from the University of Reading, and finally, some other developments.

So “What type of ‘prescriber’?” Well, you have got doctors; always been able to prescribe; no problem there.

Under these doctors you have got two new types of prescribers: you have supplementary nurse prescribers and supplementary pharmacist prescribers – I will go through them in a little bit more detail in a second – but there are another four professions who are joining that band. Optometrists are actually becoming independent prescribers, with a very limited list. Radiographers, podiatrists and physiotherapists are also going to become supplementary prescribers, and will be able to supplementary prescribe in conjunction with a doctor or dentist as an independent prescriber. I will go through it in further detail.
Then there are the District Nurses and Health Visitors – very, very limited formulary, about six prescription-only medicines; the rest of it is catheter bags, dressings, stoma bags and appliances; so not the most exciting things. We actually had a real battle to get water for injections – a very dangerous prescription-only medicine! – added on to their formulary. I think it was an oversight, but it wasn’t on there.

Independent nurse prescribers: again, we will go through the history, where they have come from and where they are at the present time in terms of both training and what they can do.

You have got pharmacists who can give out P (Pharmacy) medicines over the counter, but they have also got independent prescribing rights starting in 2007 and so independent prescriber pharmacists are going to be coming in in the very near future.

Then finally – I said it was not all types of prescribing – you have got Patient Group Directions. Now, Patient Group Directions are not a form of prescribing, but I will go through them nevertheless, because there are so many nurses that are using them.

**History of Nurse Prescribing**

Baroness Cumberlege did a report in 1986. She was looking into care in the community from nurses and what she saw was that nurses very often knew what they wanted, they knew the appliance or the drug, or whatever they needed, but they were then having to go and stand outside a doctor’s door for an hour to wait for prescriptions to be delivered, and what a waste of money that was. Very often nurses are involved in actually recommending medication.

There are more and more nurse specialists out there: why should they be standing outside a door? Is it a good use of resources to get them doing that? So she recommended that nurses should be prescribing and she actually asked for a wider formulary than was originally given.

In 1989 Dr June Crown, Director of Public Health, did a report into nurse prescribing and recommended that it was introduced, and in 1994 the first pilots were set up and in 1996 it started to go Trust-wide. That rolled out District Nurse and Health Visitor prescribing, with a very limited formulary again, as I said, mainly catheters, dressing, and things like that, but there were about six prescription-only medicines on there. There are some fantastic articles that I have read of nurses when they first started prescribing from this formulary; how they wrote out a prescription, handed it to the patient, snatched it back, checked it again, handed it to the patient, snatched it back, gave it to the patient, went off, had a sleepless night and then started to calm down because they realised that all they had prescribed was some barrier cream for the baby’s nappy rash. But they were absolutely petrified when they first started; they rolled it out very, very slowly, very, very responsibly and they did a cracking job, and there are a lot of District Nurses and Health Visitors out there who are using the formulary, but there are also an awful lot of them who aren’t. Only about 50% of the 30,000 nurses that are qualified to use the formulary are actually doing so, and the reasons behind that are probably the fact that some of them were forced into it in their training; they were told “This is part of your job and you will do it”; and so some of them don’t use it, they’re not happy to use it, even though it is very limited.

In 2002 extending the formulary of nurse prescribing came on, and there were originally about 120 prescription-only medicines which could be prescribed for four main areas: minor injury, minor illness, palliative care and health promotion. There were real problems and they kept on adding to the formulary and they kept on adding to the conditions, but matching the conditions and formulary was really complicated. You could give one drug for one thing and not for another, and basically it was very, very hard to actually put into practice. I could treat someone with Flucloxacillin for impetigo but I couldn’t use Flucloxacillin to treat an IV drug user who had an infected injection site; same infection, same drug that would actually clear it up, but unfortunately it wasn’t on my list of conditions. So it was very limited.

In 2003 the Government introduced supplementary prescribing, and again we will go into more detail as to what supplementary prescribing means, but basically this opened up the whole formulary, but there was a real paper-trail to it, which made it very hard to implement, but it is still out there in practice.
In November 2005 they announced that they were going to open the formulary, which opened up in England on 1 May 2006 to nurses. In Scotland it was 31 May 2006 and in Wales and Northern Ireland they haven’t actually implemented it yet. However, what this meant was that we were going to be able to prescribe nearly the entire British National Formulary, with the exception of some controlled drugs. The medical profession were up in arms about it in November, saying how dangerous it was and how it was the end of the world. Luckily, the day that it came into force – May 1 – we did not suppress these views, at the request of the media, it was all recorded, and then what happened is that Wayne Rooney injured his foot, so it went down in the priorities for the media and how widely they reported it, but it did come into force on May 1.

Current Figures
Of nearly 30,000 District Nurses and Health Visitors, as I said, only about 50% of them are actually prescribing. There are about 8,500 who are working as independent extended nurse prescribers, and about 8,000 of them are also qualified as supplementary prescribers. There is a reason that there is a difference in the numbers there. First independent prescribing came in and then supplementary came in as an add-on qualification. They have now been amalgamated into the same qualification, so now when you qualify you qualify as an independent and a supplementary prescriber. However, some of the first 2,000 who did independent prescribing never wished to do supplementary prescribing and so they never did the top-up qualification, and there is no need for them to now that the formulary has opened up if they are only going to be independent prescribers. They will never be able to supplementary prescribe, but that seems fair for their particular area of practice.

Patient Group Directions
There are about 670,000 nurses in the UK and around 50% of them have used Patient Group Directions within their practice, so there are huge numbers of nurses that are using these.

Types of Systems Available to Supply and Administer Medicines
These are:
- independent prescribing;
- supplementary prescribing;
- District Nurse and Health Visitor formulary; and
- Patient Group Directions.

We will look at each of these.

Independent Prescribing
This is the training to become an independent and supplementary prescriber. It is 27 study days and 13 days in practice over a three to six month period. It sounds minimal. The medical profession has said, “Actually, this doesn’t compare with my five years of medical school”, but I will go into some more detail about the types of nurses that are doing this, which will hopefully reassure you. They get rigorously assessed at degree level, they have OSCEs (Objective Structured Clinical Examinations), so they are examined on their clinical performance in a scenario, and they have a portfolio which they have to put together and which they are encouraged to carry on using and developing as they are in practice, and they have a final exam, with essays and short answers. They have also recently brought in a series of calculation skills – it is very, very important that this came in – and it has got 100% pass mark on it. I taught, on a course, in Cambridge to nurses and pharmacists, and some of the standards of mathematics of very senior nurses was pretty poor, and so I am glad that this additional standard has now come in. The Welsh brought it in first, a very good idea, and we
have now brought it in as a UK-wide standard. The students get 20 to 40 credits at Level 3. This is the equivalent of doing about a third of your final year of your degree. Most of the nurses going through it have got their degree, but it is just for those people who haven’t, to actually put towards their degree. Some places are offering the course at Master’s level as well, and there are now distance learning courses available. Employers who wish to put people through the courses have to prioritise who they are putting on it, and this has become more important recently because there are fewer and fewer places available.

So in November last year there was a consultation saying “What should we give nurses in terms of opening up the formulary?” Should there be no change, should they keep a list of conditions and a list of medicines, should they expand the list of medicines and limit the list of conditions, should they do it the other way round, or should they open up the formulary? And what they actually chose was to open up the formulary.

So this now means that qualified independent extended nurse prescribers can prescribe any medicines for any condition within their own competence, with the exception of certain controlled drugs – there are 12 CDs, Schedule II Controlled Drugs, that are on the list, mainly in palliative care but also for post-operative pain, cardiac pain and trauma, which nurses can prescribe. As I said, it has been implemented in England and in Scotland but Northern Ireland and Wales are proceeding at different times.

Supplementary Prescribing

Supplementary prescribing is defined as “a voluntary prescribing partnership between an independent prescriber”, who must be a doctor or a dentist, in the case of supplementary prescribing, “and a nurse or pharmacist” or very soon the other three professions, radiographers, podiatrists and physiotherapists, “to implement an agreed patient specific Clinical Management Plan with the patient’s agreement”.

There are examples of these Clinical Management Plans on the Department of Health website. Now templates can be as limiting or as open as the independent prescriber and the supplementary prescriber agree. So, in theory, for a newly qualified nurse or a newly qualified prescriber in a new field, they might limit it down to, say, insulin – “You can prescribe, this type of insulin between this dose and this dose”, and put a range on it, “anything else you come back to me”, or, for a diabetic specialist nurse working in that field, they could say insulins which will achieve the optimum HbA1c result (this is the blood test to show how well your blood sugar is controlled). So they may just give a parameter of what you are trying to achieve and leave it up to the Supplementary prescriber, and that is to be agreed individually, but it has got to be with the patient’s agreement. Now, some people are actually giving the patient a copy of their Clinical Management Plan, which they believe may well aid concordance with medicine; in other words, the patient is going to see what they are trying to achieve and actually be involved in that decision-making, but it also aids in terms of consent from that patient that they understand what is going on.

Sarah Mullally, the Chief Nursing Officer at the time, said that there would be no legal limit on conditions that can be included in supplementary prescribing and that supplementary prescribers could prescribe all medicines currently prescribable by doctors, with the exception only of unlicensed medicines (except in specific circumstances, which was a certified clinical trial) and controlled drugs. These have now changed, so that definition is already out of date, and now you can supplementary prescribe all medicines, including controlled drugs and all unlicensed medicines. Now, that really does open it up, but the security is there that you have a Clinical Management Plan which is done in dual partnership between the independent prescriber, the doctor or dentist, and the supplementary prescriber, the pharmacist or nurse, and, as I said, the other three professions coming on shortly.

So what have we learned so far from independent and supplementary prescribing? There are some real problems with the formulary, problems with the formulary when it was limited down to 120 prescription-only medicines and certain conditions. I could give an aspirin for a headache, even though there is no evidence out there of how aspirin works on a headache. I couldn’t give aspirin to someone having a heart attack, even though there is tons of evidence
showing why I should be giving aspirin to someone having a heart attack. So what you could do is you could give them a nitrate, which would open up the blood vessels, give them a headache, and then you could give them the aspirin for the headache, but you had to be creative in how you did this.

Southampton Research

The University of Southampton looked at nurse prescribing and showed that patient satisfaction is high, it also showed that nurses were safe, they were competent and able to do their nurse prescribing.

There are often complexities to supplementary prescribing, in implementing an individual Clinical Management Plan for each patient. If you have got 2,000 asthmatics in your practice, getting all of those asthmatics to have an individual Clinical Management Plan that needs to be agreed by the doctor and the nurse is actually quite a paper-chase. Frustrations of influencing the prescribing in practice, getting hold of prescription pads, computer generated prescriptions, all of these things were very, very difficult when we first started off. It took me five months from date of qualification to being able to get a prescription pad. It just shows the speed of things in the NHS sometimes. There are also training difficulties. A lot of the nurses were very senior nurses and ran their own clinics. It wasn’t all that easy to let someone out for 40 days over a six-month period, you really had to look at how you were going to be able to release them.

So what we would change? Open up the formulary. This has now happened, so we haven’t got the list of conditions and drugs. Flexible training, which is now available; there is now distance learning available; and systems in place so that nurse prescribing can roll out upon qualification.

Private Prescriptions

Nurses can privately prescribe, just as doctors can; so can pharmacists. If they are independently prescribing they can just write out an independent prescription as a private prescriber. If they are supplementary prescribers they are still able to do it, but they still need to have that agreed Clinical Management Plan in place before they do it. There are the same regulations as there are for doctors, but there are going to be some changes for Schedule II controlled drugs.

Now the changes are that when we started off with Shipman, we looked into the private prescribing of Schedule II controlled drugs, so morphine, diamorphine, pethidine, all of these injectables, and the thought was that actually they didn’t know how many privately prescribed controlled drugs were out in the community. They could check up on Harold Shipman and see how many drugs he prescribed, because these were on FP10s (on the NHS prescription pads), but there weren’t any audit trails in place, because a private prescription could be written on the back of a “fag packet” and it doesn’t go off to the Prescription Pricing Authority, but is kept in the pharmacy, there is no audit trail. So the Department of Health and Home Office are now standardising private prescriptions for Schedule II controlled drugs, and this is a very recent development, so that the authorities can now make sure and have a look and see who is prescribing privately.

District Nurse and Health Visitor Prescribers

These have a very short training period, but a very limited formulary, as I said, just six prescription-only medicines. It is linked to their specialist practitioner degree pathway, so the only way that they can actually do this qualification is to train as a District Nurse or as a Health Visitor, or soon as a School Nurse. This group of nurses are able to use this qualification outside of community care. That only came in in 2002. Up until 2002 they had to use it only in primary care out in the community, but then the Department of Health
changed the legislation in 2002 for nurse prescribing and this allowed them to use this qualification in secondary care as well.

**Patient Group Directions**

As I said, it is not a type of prescribing. It is a written policy allowing certain professions to supply and/or administer a specific medicine to an unknown patient in a known situation. So basically when I worked in a minor injuries unit we had no doctor and if a patient came in, I didn’t know his name but I knew that he had a tetanus prone wound, and he required tetanus, then, using one of these, I was able to supply and administer a tetanus to him. It’s not prescribing and I do have some concerns with PGDs. The authority comes from the organisation, and that’s fine. A senior nurse/senior pharmacist/doctor/manager all sign them, but they have variable training from Trust to Trust. There is no statutory training, there are no statutory assessments and there some concerns over the safety of some of them. From my point of view, I found it very bizarre that, when doctors were very anti nurses prescribing and didn’t want them to be able to prescribe, even from the limited formulary, they were quite happy for all of their nurses to use PGDs where it suited practice, yet there was no training and there was no assessment. Compare this with prescribing, which had much more rigorous standards put in place.

**Recent Developments in Patient Group Directions**

Professionals that can use PGDs can now administer diamorphine for cardiac pain in a coronary care unit or an A & E unit under PGD. That in itself has problems. It has geographical problems. What happens if you recognise that someone is having a myocardial infarction in a minor injuries unit? You can’t actually give them any diamorphine to make them pain-free. If a technician ambulance crew turn up they can’t give them any diamorphine. I’ve worked in a Minor Injuries Unit 30 miles away from District General Hospitals. The patient is suffering all of that time, even though everyone recognises what is going on. Staff able to use PGDs are also able to supply and administer all Schedule IV and V controlled drugs, with the exception of anabolic steroids. These are the lower grade controlled drugs, such as co-codamol, and co-dydramol, in tablet form. We are lobbying at the moment for changes around the geographical restrictions and also to increase conditions and also to increase drugs that can be prescribed by independent nurse prescribers, with the exception of anabolic steroids. These are the lower grade controlled drugs, such as co-codamol, and co-dydramol, in tablet form. We are lobbying at the moment for changes around the geographical restrictions and also to increase conditions and also to increase drugs that can be prescribed by independent nurse prescribers.

There are some non-NHS organisations who are also able to use these Patient Group Directions, as long as they are registered with the Health Care Commission, so private clinics, private hospitals, defence medical services, police custody suites, prison services are all able to use these PGDs.

**Patient Specific Directions**

Now, this is the normal way that most of us get our medicines. It is prescribed on a patient specific basis by either a doctor or a dentist. A nurse can do it as an independent or a supplementary prescriber; a pharmacist can do it as an independent or a supplementary prescriber; the physio, radiographer and podiatrist can do it as supplementary prescribers shortly, and the optometrist will be able to do it as a limited independent prescriber to administer a particular dose of a medicine to a particular patient at a particular time.

The next slide is just a statement from Shipman, the Government’s response to Shipman, which basically went through the misuse of drugs and saying that they did agree with opening up controlled drugs for supplementary prescribing but also said that they were going to expand the drugs that could be prescribed by independent nurse prescribers.
Prescribing of Controlled Drugs

Supplementary prescribers can prescribe all controlled drugs, including drugs in substance misuse, an example being methadone. They can do it, but they need that Clinical Management Plan to be in place before they do so. Currently there are some controlled drugs that nurses can prescribe independently, as I said. Diamorphine and morphine are the main ones which can be used in trauma, post-operative pain and cardiac pain, and also there are about twelve other controlled drugs which can be prescribed independently in palliative care (care of the dying) so that you can go in and make sure that your patients are pain-free.

Controlled drugs legislation is a UK-wide thing, so when we are looking at the devolved administrations of the UK, as I said, nurse prescribing is coming out at different speeds across the different countries, but the CD legislation remains UK-wide, and we must remember that these changes, very bold changes – even though I have been lobbying for them, I still think that they are very bold in light of the fact that the Shipman Inquiry was still going on at the time. This man killed 250 patients and when they actually arrested him he had enough diamorphine to kill another 300 in his possession and he really was planning to do further harm.

Moving on to education. George Bush once said: “You can teach a child to read and he or her will be able to pass a literacy test.” I do love the man. Education surrounding prescribing does need to be continual. CPD is really necessary and one of my big fears at the moment is that with NHS deficits, training budgets are the first thing that people are dipping into and whipping money out of. It is not fair to train nurses and train nurses to be able to prescribe and then leave them with no CPD, and it is a real bugbear of mine at the present time. The nurse prescribing qualification does not mean that nurses are free to just go and prescribe anything and everything. It is like passing a driving test. It’s basically “Yes, you’re now safe to start learning to prescribe”. It really is an opening step and I think that CPD really is needed to be able to expand nurse prescribing.

Training and Education

The Advisory Council on Misuse of Drugs (ACMD), part of the Home Office, has stressed the importance of adequate training for new prescribers, but we haven’t got some of these bold statements, unfortunately, on CPD and we really do need this from some of these hard hitters.

It is very, very important that whenever nurses go to prescribe, if they are not happy to do it, then they don’t, whether that is prescribe or supply and administer under Patient Group Directions. Patient safety has to be paramount at all times.

Training and Education – Undergraduates

The NMC are currently looking at the fitness to practise at the point of registration; this is the undergraduate training; and they are adding some very rigorous steps, including calculation skills, increased pharmacology, etc, etc, not to allow these nurses to prescribe upon qualification. They will be competent to use Patient Group Directions upon qualification, but not prescribe.

They are also looking at postgraduate education. Very rigorous standards for prescribing were produced by Liz Plastow at the NMC. They are available online. I went to a meeting last week with the Controlled Drugs Advisory Group, which is looking at education for doctors, dentists, nurses, the whole caboodle of prescribers, and they commented on the quality of the Nursing and Midwifery Council’s work in producing tough guidance.

Continuing Professional Development

As I said, there are major concerns at the moment because money isn’t always accessible, but we are trying to make sure that it is going to accessible and the NMC are going to be producing some standards on what is required from CPD in the near future.
Here’s a wonderful thing to put on your Christmas list. A copy of *Independent & Supplementary Prescribing – an Essential Guide*, from Cambridge University Press. (I get £2 a book.) It is the book that we put together for students on prescribing courses. It’s got pharmacology in there, life sciences; it’s got calculation skills, consultation skills, the lot. We only edited it. We put it together with experts from each of the fields and it is a very, very popular read for people going on the course, but it has also become a popular read for medical students as well.

**Attitudes to Nurse Prescribing**

George Bush said: “The French don’t have a word for entrepreneur.” John Reid, when he was Health Secretary, did have an idea about nurses becoming entrepreneurs. He wanted to see them employing doctors, becoming partners in practices, setting up limited companies, sub-contracting to the NHS, freeing up talent, offering choices to patients. Now, the only way that he could bring all of these things together and redesign the NHS was to allow nurses to be able to prescribe, so it was a major part of the NHS plan and a major part of the redesigning, whether you like it or not, of the NHS.

So I will just quickly slip through some slides that have been put together by Professor Molly Courtenay, who I worked with at the Royal College and who also works as a Professor at Reading University. She was involved in the initial Southampton University research evaluating nurse prescribing and she is now continuing her work in trying to demonstrate how safe it is and how well it is going.

Professor Courtenay has found out that patients are generally very positive about it. It showed that there was time-saving, it was convenient, there was continuity of care; you were looked after by the same practitioner from the start to the finish; and that patients got more information about medicines from nurses, probably down to the fact that consultation time with nurses is longer than it is with medics. Nurses also felt that they were better at giving information about medicines; again very similar things, time-saving, improved communication and increased satisfaction in their own work. Some nurses did have concerns about making a diagnosis and they also had concerns about their pharmacological knowledge, but again this is highlighted in their CPD requirements and what they want from there. There was also a fear that they were moving towards the medical model of care and being more systems based and maybe less holistic in how they were looking at patients. So the aim was to actually provide an overview of prescribing in independent and extended supplementary prescribing and to look at the factors that inhibited or facilitated it.

She did a national postal questionnaire with in-depth case studies in some of the settings. She sent out about 1,200 surveys and got 73% back, which is not a bad response rate, and it showed some of the following. As you can see:

**Areas of Practice**

A lot of nurses work in general practice and in the community. A lot of these specialist nurses will probably be in the community or both primary and secondary care, but only a few work in secondary care. The figures show that 82% work in primary care, and another 7% work primarily in primary care, so 90% odd work in primary care and only about 10% in secondary care. Now, this was when the formulary was very, very limited. What I think you will probably see with some of the specialist nurses in secondary care, is more of them coming onto courses, because the formulary now matches their job and what they are doing.

**Qualifications**

As I said, a lot of the medics complained that our 40 days training to become a prescriber didn’t match their five years of medical school, but this course is a degree level course, so the nurses who are at certificate or diploma level are actually doing it as part of their degree. The other 75% have got a Bachelor’s, Master’s or even PhD, so, you know, they are well
qualified; they have done their nursing very often before they have done their Bachelor’s degree or their Master’s degree, so they have probably had about seven or even eight years of formal education and of specialising within their field.

**Years of Post Registration Experience**

Again, there were concerns over the fact that we were all junior nurses and all newly qualified and we were going out there and prescribing. Almost 95% of the qualified prescribers have in excess of ten years’ experience, so they are not junior nurses. These are senior nurses who have specialised, they have become well qualified and they are then actually going in and doing the job.

We have also seen, as I said, a lot in the press about the objections from medical staff, but only about 2% of the nurses who had undertaken the course saw objection by medical staff as a barrier. There were other barriers, like the inadequate formulary and not being able to get prescription pads. The doctors’ magazine *Pulse* recently said that 90% of doctors saw nurse prescribing as dangerous, and that it was unsafe for patients. That was 90% of a survey of 300 people. There are 8,500 qualified nurse independent and supplementary prescribers out there who have had medical facilitators helping them gain the qualification. It isn’t as bad as they have been hyping it up in some of the press.

**Areas of Clinical Speciality**

Looking at the results in terms of which clinical areas these nurses are working in you can see that coronary heart disease, asthma and diabetes are the big chunks, and that is what you would expect, the big disease groups where a lot of these nurses are Nurse Practitioners in general practice, where they have been running the diabetes clinic or the asthma clinic for 10 or 15 years. The only thing they have not been able to do is prescribe and very often they have been actually recommending the prescription. The next finding did concern me a little bit. Only about 40% of them had undertaken any Continuing Professional Development since qualifying. Whether that is down to money, whether that is down to the fact that some of them may be newly qualified, i.e. within a year or two, and they may not have deemed it necessary to go on any CPD yet, I hope that is the case and I hope that more of them will do some formal CPD.

The next slide demonstrates some of those CPD needs. As you would expect, 25% wanted updates on prescribing policy. They want to know what is going on in law, in terms of where they stand, indemnity, policy within the Department of Health, policies within their Trust and organisation. For any of you that are interested in going out and talking to nurses about the law, every nurse prescribing conference that I have been to, when a lawyer comes on to stage they all sit bolt upright and listen. It is usually the best lecture in terms of feed-back from the conference point of view. They all want to know where they stand, they all want to listen and find out where they actually may go wrong or how to keep things right and safe. Other CPD needs include the management of conditions, pharmacology and diagnostic skills.

**“Looking Ahead”: Where Are We Now?**

Nurse prescribers can prescribe from the entire formulary, with the exception of a limited number of controlled drugs. Supplementary prescribing does remain, and it will remain there for two reasons. Firstly, it will remain there for newly qualified nurses or nurses new to a speciality as a clinical governance tool, a way of “taming them” in and supervising them whilst they start off prescribing in that area of practice. The other reason it is going to stay at the moment is because it is the only way to prescribe unlicensed or other controlled drugs that aren’t on the formulary. So for example, in substance misuse, as I said, you can only supplementary prescribe certain medications at the moment.

More nurses will now train as nurse prescribers and a lot of the courses around the country are over-subscribed because the formulary now matches what they are doing in practice, but
Continuing Professional Development is really, really important and it is the best way of ensuring patient safety. We must treat this new responsibility with the utmost respect, as we can now prescribe nearly all medicines that doctors can, and with this extra responsibility comes extra accountability.

So which method is best, independent prescribing, supplementary prescribing, District Nurse and Health Visitor prescribing or Patient Group Directions? There are four methods there, but it really does depend on the clinician’s needs, the patient’s needs, the clinician’s competencies and where they are within their career and their level of training, their employment status and the organisation that they work for.

I have put up a few issues of concern for all aspects of medicines management, in areas that have been highlighted to me in the last few weeks. Some practices still encourage back-door prescribing – some people call it “de facto prescribing” – where the prescription is written up by the nurse and the doctor signs it and they don’t see the patient. Now, are you telling me that this is safer than the nurse actually seeing the patient, the nurse being trained as a prescriber, assessing, making a diagnosis and taking accountability for it? I don’t think it is, but some practices are still encouraging the practise. There are huge accountability issues with this, because the doctor is accountable by putting their signature on to the prescription, when they haven’t actually assessed the patient.

This also means that there is a poor audit trail as well. If the nurse actually prescribed and someone else (the doctor) has signed the prescription for a patient they haven’t seen, it doesn’t really show consistency in terms of the audit of that patient’s contact with professionals. It is poor practice and it really must stop. This isn’t normally a nurse led service, but is often encouraged by employers.

Other concerns that have come to light in the last few weeks to me, and this has been going on in fact for a while:

**Independent Sector Medicine**

It really does scare me a little bit. You have got practitioners having prescriptions from other practitioners who are remote. There are GMC guidelines on remote prescribing, but they are not always kept to to the letter.

**Clinics That Aren’t Registered with the Health Care Commission**

There are clinics that are registered with the Health Care Commission for certain practices, such as laser treatment in cosmetic surgery, but in other areas, such as fillers and Botox, and treatments such as these, they are not actually registered with the Health Care Commission.

In other places in the independent health sector, which methods are practitioners using to supply and/or administer vaccines? How are they administering medicines? I don’t know if you have seen it in recent weeks, but some supermarkets want to give flu vaccine out to patients, who are coming in and buying it. They’re buying it for £15. Well, which methods are being used – independent prescribing, supplementary prescribing, PGDs? They can’t use PGDs because they’re outside of the NHS and they are not registered with the Health Care Commission.

**Storage Facilities**

Some practice areas don’t have lockable storage fridges, and there are cold chain audits for lots of these drugs or vaccines to make sure they remain cold and below certain temperatures. Where are the clinical governance arrangements for these? And again some of these come down to clinic owners or managers, and these have been reported to me by nurses who have said “Where do I stand? What’s going on here? Is this acceptable?”

So there are areas that are of bigger concern than just prescribing in terms of the entire medicines management issue.

**Resources for Nurse Prescribers**

Here are some examples of important resources for nurse prescribers in practice.
NMC Standards on Prescribing

As I said, very rigorous. They’re online, you get hold of them, and they are of a good standard. When drafting these the Nursing & Midwifery Council involved not only doctors, nurses, pharmacists and other professional groups, but also included patients, which I think is a very valuable thing to do.

NMC Guidelines for the Administration of Medicines

These are currently being reworked, but again very, very important for all nurses to actually know and to have read.

The National Prescribing Centre

Again, online. They’ve got some standards for managing controlled drugs in the community, and they also have competence documents for both nurse prescribers and for nurses using Patient Group Directions, and these are also available online. They also have standards for prescribing pharmacists and for prescribing allied health professions, but they haven’t brought them out for doctors yet.

BNF, MIMS and Trust Formularies

Making sure that they are up-to-date and that they have these documents at hand with the most up-to-date information is vital. These are invaluable resources.

Trust Policies and Clinical Governance Procedures in Place and (Most of All) Their Portfolio

If you are either defending or attacking a nurse in the dock, I hope that they bring out their portfolio, because that portfolio will be the one thing that should be good for their defence in showing what they have gone through, with reflective practice, which areas of prescribing they have worked in, what decision-making they have used, which clinical guidelines they have used to support their decision. So it is all evidence-based and, as I said, it will demonstrate both that, under Bolam, their body of peers will find it is acceptable practice but also that their practice is evidence-based.

Finally, I would like to end my presentation with one last George Bush quote. He said: “I have opinions of my own, strong opinions, but I don’t always agree with them.”

I do, however, believe, in my opinion, that independent prescribing from the entire formulary, limited only by practitioners’ own competencies, will revolutionise the nursing profession and the care that we can deliver.

There are some useful websites out there – the Chief Nursing Officer’s website and the Department of Health, National Prescribing Centre, the NMC, a Nurse Prescribing website, the RCN, the Royal Pharmaceutical Society, the Health Professions Council and, for any controlled drugs legislation, the Home Office.

Thank you. (Applause)

Discussion

The President: Thank you very much, Matt. Has anybody got any questions for him?

Dr Lothe: With regard to your comment that “a private prescription could be written on the back of a ‘fag packet’” – how could that be a private prescription? I mean, you can’t be as flippant as that.

Professor Griffiths: Well, it’s a letterhead, isn’t it? It’s a letterhead with the patient’s details on there, with their GMC number or their NMC number on there and it just has to be a letterhead saying “Please supply five ampoules of this”. That is a private prescription and the authorities really had no idea what is being prescribed and by whom, in this manner.

Dr Lothe: How would a nurse do that?

Mr Griffiths: A nurse would do exactly the same, the same details, address, contact details, PIN number, “Please supply this, to this person”, but if they are prescribing Schedule
controlled drugs they would need the standard private prescription form that is coming into play. I am not being funny; I have seen private prescriptions that have been –

Dr Lothe: No, but I’ve had consultations in restaurants and I’ve written on a napkin what the person needs. No way would I like that to go anywhere.

Mr Griffiths: No, no, no, but I have seen some that have been on scraps of paper.

Dr Green: Peter Green. I am what used to be called a Police Surgeon, now a Forensic Physician. Two points. Would one solution to your concerns about the need for CPD, which I think is an extremely pertinent point, be to put a time limit on the value of the licence that your colleagues are granted for prescribing and it can only be renewed on proof adequate CPD and updating?

Professor Griffiths: I think that that is what will probably happen. Nursing and Midwifery Council registration, at the moment, is renewed every three years, and standards are being developed by the NMC which will probably bring in the same thing, that you have to re-register as a prescriber. The reason they haven’t done it at the moment is because they have been trying to get through the other standards to do with Shipman, and trying to prioritise, but I am almost certain it will come in. The prescribing qualification will be separate from the nursing qualification. This licence to prescribe as a separate qualification will be registered against the individual nurses. The reason it was felt that that might be the case is that, if it is felt that they have over-stepped the mark in some of their prescribing, they may have that qualification taken away from them. But they might still be a very good nurse and able to practise as one.

Dr Green: But presumably the one is contingent on the other though. I mean, they couldn’t retain their prescribing licence if at the same time they had lost their RGN licence?

Professor Griffiths: No, they couldn’t, but it could happen the other way round.

Dr Green: The other way round, yes. The second point was that you mentioned that in the independent sector Group Patient Directions could only be used if the area was managed or controlled by the Health Care Commission.

Professor Griffiths: Yes.

Dr Green: And you specifically mentioned police custody areas.

Professor Griffiths: Yes.

Dr Green: My understanding from the Chief Executive of the Health Care Commission just last week is that they are not sure that they do have any authority over custody areas.

Professor Griffiths: No, they don’t.

Dr Green: So how do Patient Group Directions work in police custody if the HCC isn’t involved?

Professor Griffiths: Sorry, I didn’t make myself clear. They are allowed to use them inside the NHS and in defence medical services, which are also not covered by the Health Care Commission, and police custody services, the Prison Service, which tends to be run now by the local PCTs, the local Primary Care Trusts, and private hospitals and private clinics that are registered with the Health Care Commission.

Dr Green: So in police custody it works even though it’s outside the HCC?

Professor Griffiths: Yes. There is a very good website. There is a document called To PGD or Not to PGD? – That Is the Question, developed by a lady called Beth Taylor, who is a Principal Pharmacist in London. It goes through the criteria of when you can and cannot use a Patient Group Direction and it is very worthwhile having a look at it and it does –

Dr Green: Sorry. Can you explain how that anomaly has crept in, because the Health Care Commission clearly has a very useful remit in these sorts of circumstances? What was special about police custody that it was excluded?

Professor Griffiths: I don’t know, is the honest truth, it wasn’t me that brought it in, but I think that it was probably due to the fact that there were more custody nurses going into police custody units, which has been an increasing trend in the last few years.

Dr Green: But they still need supervising and regulation.

Professor Griffiths: I completely agree, but the Patient Group Direction will come in and the organisation will take responsibility for that Patient Group Direction. It doesn’t mean that they are going to be just giving out drugs willy-nilly. Each Patient Group Direction has to be
done for each individual organisation, it has to be signed by all of the nurses that are using it, all the other health professions that are using it and they have to stick to the criteria very strictly. They only have a lifespan of two years for each PGD.

Dr Green: Thank you very much.

Dr Vincent Marks: One of the things that you have talked about is the safety for patients. There presumably are limits as to how much of a drug can be prescribed. Now, often one used to prescribe a drug “prn” or “when required” and “as required”. I happen to have had several friends who have been denied treatment by a nurse because they thought that they had already had enough of a particular drug. Now that doesn’t seem to be good practice. It may be legal, but what can we do about it?

Professor Griffiths: Are you talking in terms of controlled drugs?

Dr Vincent Marks: Well, yes, for pain relief, you know.

Professor Griffiths: For pain relief now (again down to Shipman) prescriptions are being limited to a 28-day supply and they are also being limited in terms of validity. A prescription used to be, I think, valid for twelve months; I think it is down to three months’ validity now; and there are also other limitations coming in. When patients pick up controlled drugs, in the very near future they will be asked to sign for the controlled drugs and to actually show some identification for certain controlled drugs. So it is actually going to be getting tighter, not easier, and again the reason being that when they first started looking into Shipman (Dame Janet) they saw that there was this audit trail that went from the manufacturer down to the hospital dispensary or to the community pharmacist, and then in hospital it carried on and they could see that the drug was used on this patient because of the Controlled Drugs Register. In pharmacy it went down to the community pharmacist and then it disappeared into the ether and there was nothing to be seen of these drugs or where they were.

Dr Vincent Marks: So the argument that palliative care is the answer to the last few months of one’s life may actually be a complete nonsense, because it is being restricted by the new enactments of how we are all going to be kept safe?

Professor Griffiths: I don’t think that it is going to affect patients that much because there are still out-of-hours services for palliative care; there are still Macmillan Nurses; there are still Care Plans. They’ve got lots of exciting things coming in – well, exciting to nurses – in terms of patients who can actually plan their death in some ways and what they want and actually encourage patients to be involved in their own care and what they want from things. So I don’t think it is going to affect patients that much by limiting a prescription down to 28 days. I take your point, but we have been through the arguments and, as I said, there were lots of people involved in the committee, not just me, doctors, pharmacists, police, everyone, and they just wanted to restrict the amount of controlled drugs that were out there in the community and to ensure that the controlled drugs that are out there in the community were being used appropriately, not misused. There have been cases, well documented cases, of temazepams – they’re called “jellies”, the old temazepams – because lots of elderly people used to sell them to drug users to subsidise pensions. So, you know, there are lots of different people out there misusing drugs. It’s not just your normal looking sort of drug user, there are other people that are selling them on, passing them on, and they really just wanted to close down on this abuse. As I said, Shipman had enough diamorphine stockpiled to kill another 300 patients.

Mrs Barber: Janice Barber, solicitor. Has there been any work done yet on the effect of nurse prescribing on the drugs bill and whether the drugs bill for the NHS will go down or up with so many more prescribers out there?

Professor Griffiths: To be honest, I don’t think it will go up an awful lot. It actually came down this year, but I don’t think that we can take the credit for that, unfortunately. I think it went down because of some hard commissioning from the NHS. Of the drugs bill at the moment only around 1% of the drugs bill, so about £66 million, is actually from nurse prescribing and the other billions come from medical prescribing at the moment. I do think that when nurses take over some of the routine prescribing in the asthma clinic, the diabetes clinic and the COPD clinic, that they will just be prescribing what the doctors were prescribing, and one of the things that did come to light when I was teaching on the course
was that with supplementary prescribing, when the nurses were going back and using these Clinical Management Plans in practice, it actually unified practices. Where they were all prescribing in different ways, the nurse went back to the surgery with a clinical management plan and signed up to the nurses’ Clinical Management Plan and when they all saw their evidence it unified the prescribing within the practice. So I think it can probably work to make things more cost-effective and clinically effective, but I don’t think that it will increase significantly. I think that where we take over prescribing, the medics won’t be prescribing any more on top of that, we will just take over some of their role.

Ms Stern: Vivienne Stern; I am a solicitor. I have to say I think it is unethical. On each occasion when someone who is not a doctor does some prescribing, the other side of the same coin is that you have a doctor who is either refusing to prescribe or abdicating from prescribing, and I don’t think that this is allowed by the GMC’s Rules of Conduct?

Professor Griffiths: Can you clarify a little bit more? Sorry.

Ms Stern: Aren’t doctors obligated to treat people? If people turn up at a GP’s practice, or wherever, and say “I have got a sore throat, I would like to be treated by the doctor, please”, isn’t the doctor obligated to?

Professor Griffiths: The doctor would obviously see the patient. Whether they prescribe or not is whether there is a clinical need for it. A lot of people come in and demand antibiotics, and we don’t necessarily give them antibiotics. I have been threatened with, legal action if I don’t give them antibiotics, but if they don’t clinically require them I also have an obligation to safeguard the use of them, because we are going to run out of effective antibiotics.

Ms Stern: I take that point, but isn’t that a clinical decision to be made by a doctor using proper clinical judgment?

Professor Griffiths: As opposed to a nurse using proper clinical judgment?

Ms Stern: Well, isn’t the patient entitled to have that clinical decision made by a doctor who went through a medical school and got the MBBS after his name?

Professor Griffiths: Oh, I don’t think it is unethical. I think that if a patient wishes to see a doctor they can see a doctor. If they wish to see a nurse they can see a nurse. Very often what we found from some of the research is that they actually prefer to see the nurse, but that is their decision. It is not taking away their options, it is adding in options to them.

Dr Lothe: I am a doctor. Can I just add to that. I think what happens in reality is that you have protocols of what a nurse is allowed to do and not allowed to do, so if you were allowing her to sit in for a doctor with certain criteria for giving antibiotics, then that is something that would be agreed between the two of you. You wouldn’t do it without some kind of consent. I am just trying to put it into perspective.

Professor Griffiths: Yes. I mean, I work at a Walk-in Centre, as a Senior Nurse in a Walk-in Centre, and we don’t have any doctors there, so when patients come to see us they say “We would like to see a doctor”, then we explain that we don’t have any doctors there. They can go off to a general practice or to the Accident and Emergency unit and see a doctor if they wish, but we see 50,000 patients a year and they are quite happy being seen by nurses. I think that nurse training has developed over the years and nurses aren’t there just to mop doctors’ brows and make cups of tea. We have moved on a little bit.

Dr Czaykowski: I am Andrew Csakykowsk, a jobbing GP from near Maidstone. I did belong to your 10% of keen doctors who were in favour of nurse prescribing until this evening. I am now a very worried ex-member. Do I understand that the entire MIMS content is prescribable by a nurse prescriber?

Professor Griffiths: Yes.

Dr Czaykowski: And more; and unlicensed drugs as well?

Professor Griffiths: Unlicensed if they’re –

Dr Czaykowski: I can think of all sorts of scenarios where I wonder whether a nurse making a mistake is actually insured, if nothing else.

Professor Griffiths: Yes, okay.

Dr Czaykowski: Is her insurance, say, able to face a £1m law suit in case she hadn’t checked whether a patient was insulin allergic and gave her Moexipril, or got the decimal
point wrong on her insulin, or anything else which causes sudden death, you know? I feel uneasy now.

**Professor Griffiths:** As a matter of interest, most nurses have been gate-keeping medicines for many years, administering medicines over many years, and so those same errors – and there will be errors; I grant you there will be errors; but there are errors in medical prescribing as well. Some of those errors –

**Dr Czaykowski:** They are insulated, are they?

**Professor Griffiths:** They are insured. They are covered by the Royal College of Nursing for £3m of indemnity, so they will cover your £1m. The £3m indemnity does cover the nurses within their practice. They will also be covered for their vicarious liability through their own employer primarily, and that is why the clinical governance procedures need to be in place before they actually start prescribing. Now, the nurses that are fouling up within administration of medicines would be the same nurses that would foul up within prescribing, but you have that within the medical profession as well, and in some reviews of prescribing by medics in some Trusts, which have been duplicated around the country, they have done audits of unsafe prescriptions – no age, wrong weight, micrograms instead of milligrams, or the other way round, illegible writing – and basically from one District General Hospital over a month, from the Out-patients Department and the TTOs, 50% of prescriptions were classed as unsafe by the Pharmacy Department.

**Dr Czaykowski:** But there are other issues here. You are implying that a nurse is able to diagnose a condition and prescribe for it?

For the last quarter of a century I am quite used to phone calls from the nursing home, saying, “Am I allowed to double this diamorphine dose in the syringe driver, because the person is dying and they are distressed?”.

I would say “Yes”. Now, as I understand it, she does that independently?

**Professor Griffiths:** She does that independently.

**Dr Czaykowski:** They are entitled to do it independently.

**Professor Griffiths:** They would be able to. If they are a qualified nurse prescriber, if they

**Dr Czaykowski:** That is why I am scared. Can you understand why?

**Professor Griffiths:** I can’t; I can’t.

**Dr Czaykowski:** No.

**Professor Griffiths:** I am just trying to explain that nurse practitioners have been around for 15/20 years in the UK. There is also the fact that these 40 days of training over a six-month period is just on prescribing. It doesn’t teach them their speciality, it doesn’t teach their advanced practice skills. They will have to have those other qualifications before they start prescribing. So it is not a case of these guys are just coming in, doing 40 days and then going out prescribing willy-nilly. The prescribing does take place under a very supervised process to build up their portfolio. They are assessed rigorously, the calculation skills are 100% pass mark. You know, they really do have –

**Dr Czaykowski:** They would also diagnose medical conditions?

**Professor Griffiths:** Yeah, and they have been doing for 20 years.

**Dr Czaykowski:** Oh, my god.

**Dr Lothe:** Well, within their specialty?

**Professor Griffiths:** Yes.

**The President:** Doctor, you are saying “Oh, my god” and you are shaking your head. Can you be more specific about what is so dreadful about this? You are not making yourself clear.

**Dr Czaykowski:** Well, they haven’t been through six years of medical school.

**The President:** Well, go back to your example of the syringe driver. What is advantageous about you saying that it’s all right to double the dose on a syringe driver by telephone rather than the nurse on the phone who is talking to you who is in front of the patient?

**Dr Czaykowski:** There are other issues here, not just the dose in the syringe driver.

**Professor Griffiths:** Some of the other issues though, just as a matter of interest –

**Dr Czaykowski:** There is the issue of diagnosis of medical conditions.
**Professor Griffiths:** I worked in Accident and Emergency for thirteen years. When the doctors came in they did a six-month rotation, and they came in as a junior SHO, they did a six-month rotation and they moved on to another rotation, and this happened in every hospital around the country every six months. Some of the nurses there had been there 15/20 years within that speciality and they were able to diagnose, they were able to—

**Dr Czaykowski:** Well, you get SHOs in stages, but the buck stops with the consultant, because he’s responsible.

**The President:** Dr Moffatt is desperate to ask a question.

**Dr Moffatt:** I am a colleague of Peter Green here, who is an FME, and I am a Forensic Medical Practitioner, and I understand where he is coming from, but I wanted to raise two points with you. The first is that you mentioned Shipman and you made some play with his activities. The thing to remember about Shipman, in my view, is that he was primarily a murderer, a thief, a liar and a fraudster, and a very poor doctor, in my view. So I understand where you are coming from, but they are not very thick on the ground, Shipmans, I am pleased to say.

**Professor Griffiths:** No.

**Dr Moffatt:** The thing that worries me is that you mentioned, almost in the same breath, President Bush. I can’t see the relevance of President Bush coming up this evening, unless you are equating him with the killer Shipman as a killer, but I can’t recall Bush prescribing for anybody. Finally, in 47 years of visiting custody suites throughout this great city of ours I’ve never been asked by a policeman or a prisoner—remember, Dr Green and I treat criminals all the time; all our patients are criminals. They never said “Please can I have an independent extended nurse”. I’d never heard this expression until this evening. It’s a most extraordinary expression. Perhaps you would like to just comment on that. I am trying to be provocative.

**Professor Griffiths:** I noticed. The Bush jokes, I do apologise if they weren’t to everyone’s taste, but they were put in there to try and lighten the subject a little bit and I realise that George Bush isn’t a prescriber. As far as police custody, there are nurses that are working in custody suites, in both courts and in prison services’ custody, and they are looking after patients and some of them using Patient Group Directions and some of them are prescribing, and it is happening around the country, including here in London. It is not that patients are saying, “I want an independent nurse prescriber”, they are asking to see a doctor or a nurse about their condition that they have at the time.

**Dr Moffatt:** They invariably ask for a doctor.

**The President:** Yes, but the doctor won’t get out of bed. Professor Treasure.

**Professor Treasure:** The interesting thing about this is that there is a change in the boundary and you are pushing on this boundary, and good luck to you, and history will find out what happens. The point really is this, that I have doctors and nurses under my team and the best of the nurses I would trust way ahead of most of the doctors, normally. Now, the problem is this, that around doctors there is a boundary. They have all achieved a high level of scientific training, gone to medical school, completed all those exams, and so on, and they work their way up the hierarchy. Some of them aren’t very good and some of them are very sloppy, but there is boundary which defines who they are, and the public knows what they expect of them, and they are under a jurisdiction. There is another group called nurses, who enter in another way, and many of the best of them achieve very well, but it is the crossing of that boundary that scares the medical profession. We know where that boundary is. So that is why we are worried about it. That is the problem and it is an historical definition which you are challenging and my question is does it make sense, because, you know, here is the medical profession—

**The President:** Professor Treasure, I am sorry. He has explained where he is coming from. You have said that the medical profession are uncertain about it. Justify that uncertainty. Is the medical profession’s perception well founded, in your view, of these areas?

**Professor Treasure:** No, no, I have just told you that it is an historical assumption which you are challenging, and I am just trying to say that this is the problem, that you are trying to alter a boundary…
**Professor Griffiths**: I realise that.

**Professor Treasure**: And why does it make sense?

**Professor Griffiths**: I think there are going to be more changes though and, for those of you who keep an eye on what is going on in terms of new developments, there are new developments out there. There is more blurring of the boundaries. As I said, we have got another four groups of professionals who are coming on to prescribing. We also have, on top of that, physicians’ assistants that will be doing the same job as emergency care practitioners, who are doing the same job as nurse practitioners, who are doing the same as junior doctors. There are an awful lot of professions that are coming into the healthcare system that are bringing on new roles, increasing the blurring that is going on. So I don’t think it is just nurse prescribing, I think that there are other professions that are coming in, as I said, these new professions, emergency care practitioners who are a hybrid of nurse, paramedic and junior doctor, and physicians’ assistants, surgeons’ assistants, and they’re all coming in, and the NHS is changing big time.

**Professor Treasure**: I know. But to defend myself against Bertie, if ever I need to defend myself against Bertie (that’s a bit strong), I am really asking the question.

**The President**: Selina, the last question.

**Ms Lynch**: I am Selina Lynch and I am a lawyer and Coroner. I would like to start by reversing the balance a little, because you do have at least one friend in the room.

**Professor Griffiths**: Thank you.

**Ms Lynch**: I think that nurse prescribing is a very good thing and I think it is a positive step for patients, some of whom will have their quality of life enhanced by it, and I speak from personal experience – I won’t say it in public but I might say it over tea. But what I would like to ask you about is security generally, not just for nurse prescribers but for doctor prescribers as well. You spoke about auditing. What auditing on a surgery is there, because I have been in fact having prescriptions as well and I don’t really know what is in place to monitor that prescribing.

**Mr Griffiths**: All of my prescribing is reviewed – I have a Trust prescribing lead, the Chief Pharmacist of the Trust and my Medical Director who all review my past data, so they will go through all the data of my prescribing, the amounts of prescriptions, whether it was done in line with national guidelines, whether there are any bizarre prescriptions on there. They review my past data, which then gets passed back to me with any comments, and if they were to note any prescribing parameters outside of my field, they could come down on me like a ton of bricks. If they felt that I had breached that, they could report me to the NMC for obviously stepping outside of my guidelines for prescribing, in which case, going against the NMC standards and guidelines on prescribing, I would potentially lose my prescribing qualification and potentially lose my nursing registration as well. It is not something that most of us are willing to risk. There are audit trails in place. There are Trust prescribing leads. The pharmacists look at our prescribing just as they look at the medics prescribing and audit it thoroughly. If nurses are working in secondary care, just like the pharmacists do a drug round on the ward, they write in green pen to identify that they are a pharmacist and any changes they have made, exactly the same happens with nurse prescribers as with medical prescribers. It is exactly the same standard and the same standards –

**Ms Lynch**: A bit like a VAT inspection, it is something that happens regularly?

**Professor Griffiths**: Yes.

**Ms Lynch**: Thank you.

**The President**: Thank you very much indeed. Well, I think that was a marvellous lecture and a marvellous evening.

I have never seen a lecturer before who was attacked first for the fact that people prescribe too much, then they prescribe too little, and then the ethics of another profession altogether who allowed them to prescribe, then there was a general uncertainty about their diagnostic power, while the inexperienced doctor in another speciality is much more intrinsically reliable just for the fact that they are a doctor, and then you got attacked because people in police stations don’t ask for nurses enough. I think to get such comprehensive wrath shows what a stimulating evening we have had. Thank you very much indeed. (Applause)