

Title

Introducing nurse independent and supplementary prescribing to Jersey

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Abstract

Around the world countries are introducing nurse independent and supplementary prescribing in response to increased socioeconomic and political demands. The introduction of non-medical prescribing in Jersey has been challenging but worthwhile. Non-medical prescribing, as in other countries, is seen as a safe and effective method of delivering patient care that provides significant cost savings; however, non-medical prescribers' powers and roles differ across the countries that have taken up the practice. This article documents the States of Jersey's journey from commissioning and the implementation of non-medical prescribing, to now.

Keywords: Non-medical prescribing; independent prescribing; supplementary prescribing; nursing; professional practice

Across the world, public health care is carried out in resource-limited environments. The need to provide robust, affordable and fit-for-purpose health services is the ‘holy grail’ of governments in the western world. And Jersey is no different. The epidemiological transition phenomenon (Harper and Armelagos, 2010) is changing the health-care topography, and Jersey has an ageing population with cumulative chronic illnesses, which result in multimorbidity, and, in turn, health-service deficiency. Since 2011, the capacity of some health services in Jersey has been exceeded. Implementing change and ensuring that Jersey’s services are fit for the future is problematic in the context of the isolation of a small island community. More than 10 years ago, the New Directions Strategy (States of Jersey (SoJ), 2005) identified that Jersey’s Health and Social Services Department (HSSD) was soon reaching a point where services would become saturated and cease to function efficiently. In 2011, KPMG was commissioned by HSSD to review how services are provided, what challenges are around the corner, and what approach will be necessary to ensure that the provision of good-quality care can be sustained. This review proposed a new model of care that will be ‘safe, sustainable and affordable’ into the future; and an ambitious agenda of strategic change mapped out Jersey’s proposed changes over the next 10 years (SoJ, 2012a; SoJ, 2012b).

This article outlines the introduction of nurse independent and supplementary prescribing (NISP) to Jersey. The atypical mix of Jersey’s medical workforce and its underdeveloped primary-care services enabled nurses to work at a higher level of practice where prescribing would be inherent within their professional scope. Jersey’s process of instituting non-medical prescribing was aligned to the white paper *Caring for each other, Caring for ourselves* (SoJ, 2012a), and *A New Way Forward for Health and Social Care* (SoJ, 2012b). This process was developed in parallel with a hybrid model of the PEPPA Framework (participatory, evidence-based, patient-focused process for advanced practice nursing role development, implementation, and evaluation) (Bryant-Lukosius and DiCenso, 2004)—a recognised framework based on existing models for the implementation of health professionals and advanced practitioners. This framework is designed to overcome role implementation barriers through knowledge and the understanding of advanced practice nurses’ roles and environments. (See Bryant-Lukosius and DiCenso (2004) for a comprehensive review of this framework.) While non-medical prescribing is not the dominant topic in Jersey’s approach to health-care reformation, it is part of the overall strategy to deliver services that are ‘safe, affordable and fit for the future’.

Jersey: Demographics and policy

Jersey is a multicultural population of 97 875 people (SoJ, 2011). While there are clear differences in economies of scale, Jersey mirrors similar epidemiological health trends and issues of the UK, and adopts many of the UK’s policies, guidelines and standards (SoJ, 2014a; SoJ, 2014b). Jersey is part of the British Isles, but it is not governed by the UK nor is it a member of the European Union (EU): it is an independent self-governed jurisdiction. However, British and European politics influence local health-care policy; for example, British regulatory standards and European Working Time Directive. This has an impact on health professionals’ practice and education.

Context

In 2010, Jersey's Chief Nurse commissioned the introduction of non-medical prescribing. The landscape of non-medical prescribing has evolved significantly in Ireland (with its institution in 2007) and the UK, since Baroness Cumberlege originally advocated nurse prescribing within a community framework. From the first Crown Report (Department of Health, 1989), to a limited national formulary for district nurses and health visitors, to independent and supplementary prescribing, the paradigmatic shift has been vast. The most advancing change materialised in 2006 when the *British National Formulary* (BNF; Joint Formulary Committee, 2016) was opened up to nurses in England who had completed the V300 NISP course, although there were restrictions to some controlled drugs at that time (Nursing and Midwifery Council (NMC), 2006). It is now widely accepted that nurse prescribers are safe and effective practitioners (Haidar, 2008; Latter, 2008), and the efficacy and safety of the practice has been evaluated in England (Latter et al, 2010), Scotland (Watterson et al, 2009), and the Irish Republic (Drennan et al, 2009). With this knowledge, the planned introduction of non-medical prescribing to Jersey gained momentum.

Legislation

Originally, there was no Jersey legislation to enable any professional other than doctors, dentists or veterinary surgeons to prescribe medicines. The then Minister for Health sought parliamentary approval to allow the introduction of non-medical prescribing to Jersey. In 2011, the approval was unanimously passed in the States Assembly, and this paved the way to enabling legislation that described prescribers as 'doctors, dentists, veterinary surgeons and appropriate practitioners' as directed by the Minister for Health.

Appropriate practitioners as prescribers

While this article focuses on nurse prescribers, the legislative change allowing 'appropriate practitioners' to prescribe permits prescribing by suitably qualified professionals (pharmacists and paramedics, for example) who meet Jersey's prescribing standards.

Further changes

Following this legislative change, Jersey Medicines Law (1995) was amended to allow independent and supplementary prescribing in Jersey (Amendment No. 3) (2011) and the Health Care (Registration) (Prescribed Qualifications) (Amended No. 5) (Jersey) Order (2012) proceeded this to ensure that non-medical prescribing was a local registerable qualification. In turn, the Misuse of Drugs (Miscellaneous Amendments) (No. 4) (Jersey) Order (2013) extended prescribing privileges to controlled drugs. Additionally, three pieces of secondary legislation in the form of ministerial orders were approved by the Minister for Health ensuring that by August 2013, a foundation was in place to enable non-medical prescribers to practice. *Figure 1* provides a chronological overview of the legislative changes to enable non-medical prescribing.

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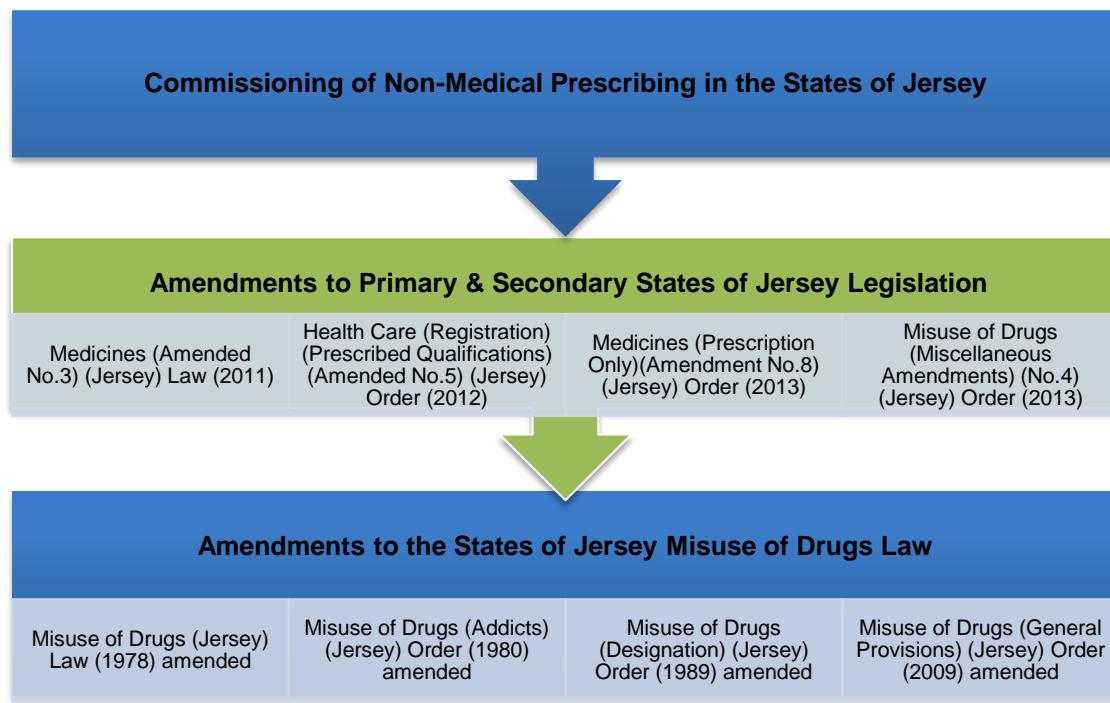


Figure 1. Legislative changes to States of Jersey law

While these legislative changes have been advantageous, there have been caveats. Principally, Jersey's Primary Care Law could not be amended adjacent to the Jersey Medicines Law (1995) due to the infrastructural formation where drug budgets and payments are linked to the social security department. Essentially, there was no primary care budget for non-medical prescribers; this presented, and continues to present, challenges. This problem is further complicated by the limited integration between primary and secondary services (KPMG, 2011). Consequently, a position was created in which non-medical prescribing can be undertaken in the public HSSD domain but not in primary care. However, the proposed legislative changes are at an advanced stage and will be amended in 2016. These progressive legislative amendments mirror the UK's increased socioeconomic and political demands, which have paved the way for boundaries to be extended (Courtenay et al, 2012).

Scoping candidates

In 2012, with legislative reforms co-occurring, a senior nurse and Jersey's Nursing and Midwifery Higher Education Department were tasked with introducing non-medical prescribing. They undertook a scoping exercise to determine the health-care landscape and identify practitioners who were ideally placed to undertake non-medical prescribing. Jersey's Nursing and Midwifery Higher Education Department affiliated with an English University, and a NMC endorsement event was held on the island to accredit the local delivery of a bespoke NISP NMC V300 programme. Designated medical practitioners (DMPs) willing to support the students in practice were also identified. Only candidates willing to undertake the V300 course that had an assigned DMP were selected, and, irrespective of cost-saving potential, no form of influence was rested on any practitioner. Mandated

cooperation between the DMP, the candidate and HSSD was agreed before confirmation of acceptance. Furthermore, specific additional criteria needed to be satisfied and these were incorporated as educational, numerical, clinical and professional prerequisites. Suitable candidates undertook a preparatory 5-day course over 4 months before commencing the V300 course to up-skill and prepare them for admission to the programme. A bespoke programme that reflected Jersey's unique position was fashioned and this was delivered on the island in partnership with an English university for the first time in January 2013. A buddy system giving peer support throughout the course was established for subsequent prescribing cohorts. *Figure 2* outlines the organisational and candidate prescribing preparation in Jersey.

INSERT FIGURE 2 HERE +++

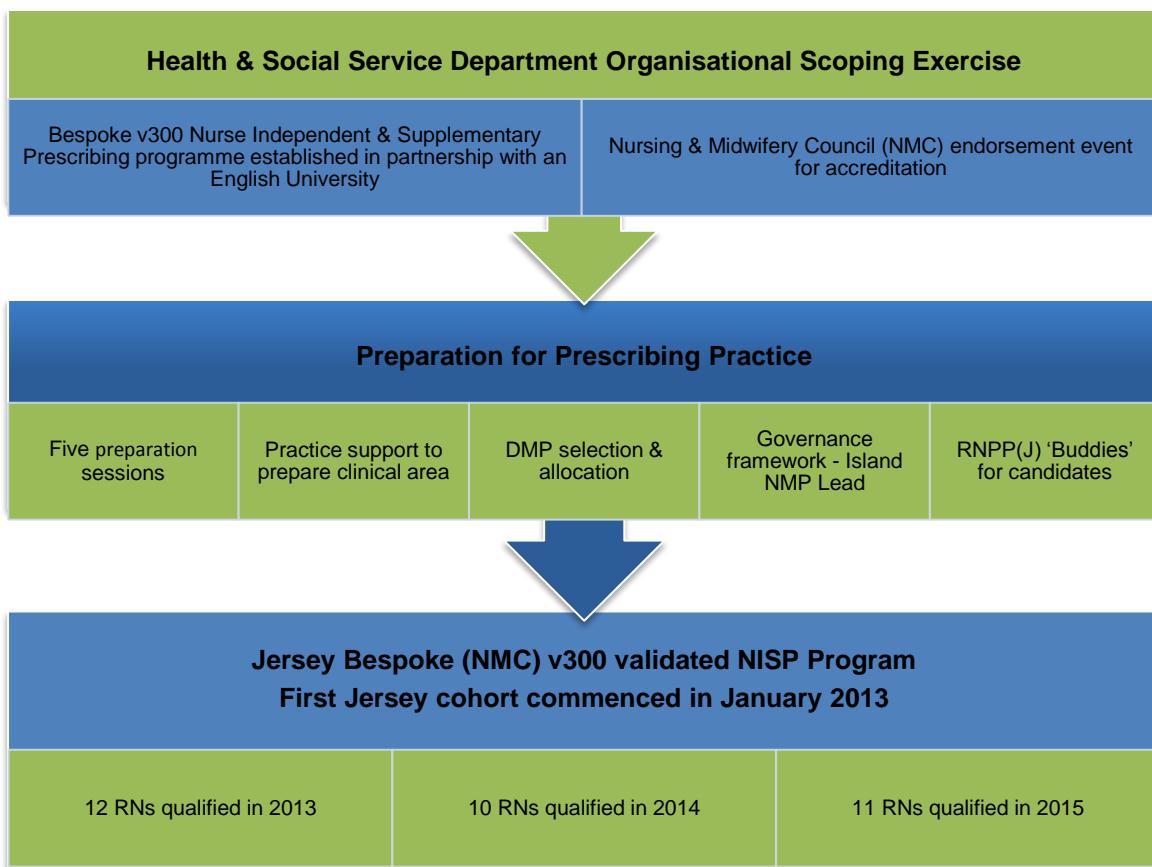


Figure 2. Organisational and candidate prescribing preparation

Competency to prescribe in Jersey

Jersey's implementation of non-medical prescribing differed to the UK's; Jersey was in a unique position to 'cherry pick' the most fitting aspects of the processes of non-medical prescribing from those of the UK and Ireland. While all nurses (and nurse prescribers) are registered and accountable to the NMC, Jersey also has its own local registration. Nurses, doctors and health professionals registered with the Health and Care Professions Council (HCPC) are required to formally register on an annual basis to practice in Jersey. Non-medical prescribing was made a locally registerable qualification. This is annotated for nurses as RNPP(J): Registered Nurse Prescribing Practitioner (Jersey). Additionally, non-

medical prescribers have to satisfy that they are maintaining continued competence to maintain their local prescribing privileges. *Figure 3* illustrates the necessary mandatory annual criteria, which are signed off by the non-medical prescribing lead on an annual basis.

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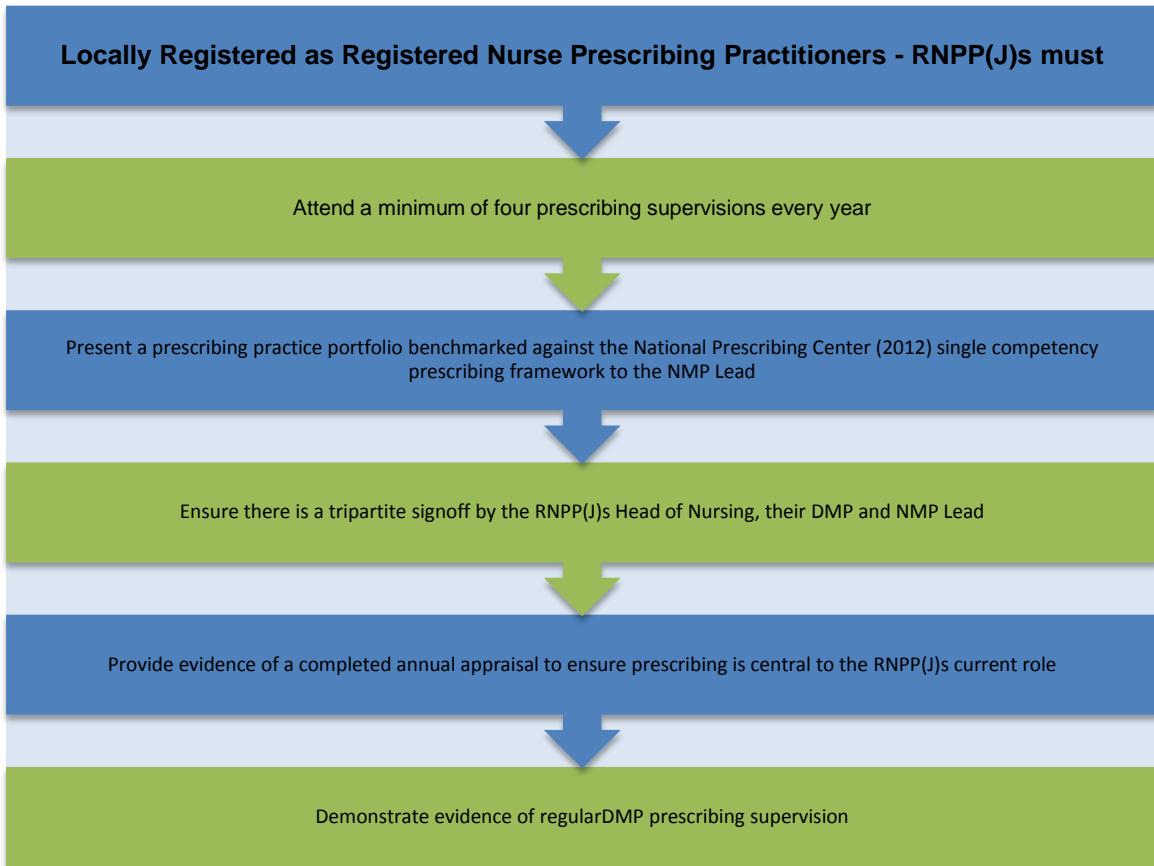


Figure 3. Mandatory annual criteria for non-medical prescribers

The island's non-medical prescribing lead has overall responsibility for non-medical prescribing in Jersey. This responsibility ensures that non-medical prescribers are practicing within their scope of competence. Competence is demonstrated through meeting with the non-medical prescribing lead on an annual basis and submitting a portfolio demonstrating continued professional development and continued capability. In addition to this, non-medical prescribers must attend four peer-prescribing supervisions over a 12-month period and continue with their DMP supervision. Peer prescribing supervision is a forum that allows non-medical prescribers to reflect on practice and discuss prescribing specific to their area of practice. This forum creates a safe environment where collaborative learning and information-sharing takes place. This has been made a legal requirement and the non-medical prescribing lead monitors attendance. An operational generic HSSD non-medical prescribing policy allows prescribers to work within a defined organisational governance framework that applies to their area or practice.

Practitioners who take up employment in Jersey with a V300 qualification should ensure that they satisfy local requirements to initiate registration as a RNPP(J). The primary aim of these processes is to ensure a robust governance framework in the interest of public

protection and patient safety. These mechanisms pre-empted the NMC revalidation requirements that came into effect in April 2016 (NMC, 2016).

Jersey now

An appraisal of non-medical prescribing was undertaken one year after its introduction to Jersey. Qualitative and quantitative responses were collated to gain an understanding of non-medical prescribers' practice. The most notable response from practitioners was that non-medical prescribing has had a positive impact on their patients. All respondents report that non-medical prescribing has significantly reduced patient waiting times in their clinical areas while allowing more timely access to medicine. Emergent themes were positive (*Box 1*), although all non-medical prescribers reported that the practice had increased their workload. Nine non-medical prescribers practicing independent prescribing issued approximately 2000 prescriptions in the first year. Interestingly, supplementary prescribing has not been used. This is congruent with reports from Courtenay et al (2012), who question its continued use when prescribers have maximum efficiency. While the number of prescriptions may seem small when compared with the millions of items issued by non-medical prescribers on FP10s every year in England (National Prescribing Centre, 2010), this number is significant within the context of Jersey. However, the number of prescriptions issued will not determine the success and significance of non-medical prescribing. It is harmful and unsafe for non-medical prescribing to be evaluated in this manner, as numbers of prescriptions do not correlate with good medicines management or patient outcomes. It is difficult to collate meaningful data on episodes of care where prescriptions are not issued, but anecdotal evidence suggests these are as frequent as prescribing episodes. Over half (55.5%) of respondents prescribe controlled drugs on a regular basis.

With this group of RNPP(J)s, there was no correlation between length of time in specialty, length of time working for HSSD and age, with the number of prescriptions issued on a weekly or yearly basis. Non-medical prescribers working in acute general hospital settings are more prolific prescribers than prescribers who work in community HSSD settings (mental health, for example); nonetheless more prolific prescribers are less likely to check the costs of medications. While these data are specific to Jersey's context, with obvious limitations, the appraisal has provided a coherent representation of how prescribing has influenced practice over the previous 12 months.

Conclusions

'I would not have me or my family subject to anything other than the highest level of care and prescribing, which is that provided by a fully trained doctor' (Day, 2005).

Times are changing. Since the inception of non-medical prescribing in Jersey, the support from medical staff has been very positive. Non-medical prescribing's success has been fashioned through this support, which has been highlighted as an important component in the literature (Nolan and Bradley, 2007). The recognition that nurses can and do prescribe within their scope of competence or indeed capability (Nazarko, 2016) has been the catalyst for the development of more autonomous and advanced practitioner levels of practice in Jersey. Reassuringly, the evidence is clear; nurses prescribe for a wide range of patient groups, comparably with physicians, and their episodes of prescribing result in similar

clinical outcomes (Gielen et al, 2014). For the first time in Jersey, nurses have been able to fulfil the scope of professional practice, and, where medicines management is involved, provide complete episodes of care. This includes management from admission to discharge (including referral) in acute services, and the management of acute or chronic illness in some areas in the community. This is in line with service reconfiguration and endorses the principles advocated by the SoJ white paper (SoJ, 2012a) and strategies (SoJ, 2012b). The publication of Jersey's primary care strategy—an outcome of SoJ (2012a; 2012b)—in 2015, is another encouraging indication of Jersey's progress in recent times. But there is still much to do. Non-medical prescribing in Jersey has significantly contributed to service redesign and providing quality care outcomes (SoJ, 2015). The integrity of this process must be maintained and further developed in its current format in line with local, national and international policy and directives.

Key Points

- Non-medical prescribing was successfully introduced to Jersey in 2013 and incorporates a bespoke advanced practice model
- Non-medical prescribing is a local registrable qualification and legislation requires prescribers to complete ongoing continuing professional development and re-register annually
- Further legislation is expected in 2016 to extend non-medical prescribing practice to primary care
- An evaluation of non-medical prescribing in Jersey has evidenced continuing health service reform

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