MLX 273: PROPOSALS FOR INDEPENDENT NURSE PRESCRIBERS
SUMMARIES OF RESPONSES FROM NURSING, MEDICAL AND
PHARMACEUTICAL ORGANISATIONS WITH SELECTION OF
COMMENTS FROM OTHER ORGANISATIONS AND INDIVIDUALS

A
NURSING ORGANISATIONS

Royal College of Nursing
Need to have guidance on the importance of nurses having relevant experience prior
to prescribing. Questions method used to draw up list - data set 10years old.
MCA/DH should ask prospective nurse prescribers for suggestions for additions to the
list. List falls short of being comprehensive but is a step towards preferred position of
nurses having access to as wide a formulary as possible. Think NPF should contain
all medicines available to medical practitioners when treating conditions within the
designated categories. Close association of available POMs with pre-determined
conditions should be reduced. Prefer wider list of POMs. CDS should be included.
Asks how formulary will be updated.

English National Board for Nursing, Midwifery and Health Visiting
Document only refers to nurses not midwives and health visitors. Welcome inclusion
of antibiotics and believe nurses etc are capable of prescribing from the wider list.
Agrees with proposed list of POMs. Not clear in Annex C why some drugs have been
excluded when each is an alternative to a drug that has been recommended for
inclusion eg Azithromycin for Erythromycin. Re definition registered midwives
should be explicitly included. Agrees with proposed eligibility criteria but it may be
helpful to review the position once prescribing is an established part of practice.
Aware of some concerns re range and scope of prescribing eg some concern that only
registered children's nurses prescribe for children. However, imposed limitations of
this nature may prevent legitimate prescribing by others eg health visitors.
Educational preparation should address prescribing limitations. Notes that nurses etc
who are selected will have demonstrated appropriate expertise and together with
ENB's code of practice this will act as a control mechanism. Palliative care -
contradiction between statement that nurses in this area will have additional skills to
assess/manage symptoms and the reasons for not including opioids. Based on
experience, nurses would be able to give enhanced care if able to prescribe opioid
analgesics.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting
Supported option 5 but welcome option 3 which allows prescribing albeit from a
reduced formulary. Term independent nurse prescriber could lead to confusion as the
adjective "independent" is applied to the nurse rather than the prescribing process.
Might suggest working outside the NHS. Also, term nurse prescribing inappropriate
for midwives. Prefer "independent prescribing by nurses, midwives and health
visitors". Wish to draw attention to the second level practitioner who are accountable
for their practice and shouldn't be disadvantaged in developing it. Recommend they
are not further excluded from developments. Agree with entry requirements for
training and has developed standards which will enable the Council to record those
successfully completing the training programme. Standards will be a base line across
UK but content of courses will also reflect req'ts of local commissioners. Support
wider list of antibiotics. Add WFI to list. Request that midwives are given access to diamorphine.

National Board for Nursing, Midwifery and Health Visiting for Scotland
Agree entry requirements, list of POMs and wider list of antibiotics.

Practice and Policy Group, Royal College of Nursing
Should have extended nurse prescribing bearing in mind what nurses do at present eg management of chronic diseases. Discusses the number of credits a student will achieve as a result of undergoing training. Need a special register for prescribers who should limit their prescribing to their particular areas. Should be standardised courses

Welsh National Board for Nursing, Midwifery and Health Visiting
Fully support the proposals

Royal College of Midwives
Midwives can already prescribe and administer limited range of medicines in their work. Would find it unacceptable if they had to retrain in order to prescribe the same medicines. Any new training for midwives should be under the umbrella of continuing professional development. Dept of Health has given assurances that the definition of nurses eligible to prescribe includes midwives. This is not reflected in the proposal which needs to be changed. Share anxieties about prescribing of antibiotics in the light of development of resistance.

Joint Committee of Professional Nursing, Midwifery and Health Visiting Associations (JCPNMHVA)
Suggested formulary could be considered lacking and restrictive for specialist nurses. Pleased that criteria for eligible nurses is not too prescriptive but concerned that a generalist nurse would not have knowledge, training and experience in specialist area such as dermatology to assess, diagnose and prescribe. On training, concerned that the course will be insufficient to train nurses to diagnose across such a diverse range of conditions. Also, it is unrealistic to expect one mentor to cover all the areas. Better model would be for nurses in a particular specialism to be mentored by a specialist in the same area. Difficult to comment on the proposals in isolation without knowing how they fit with the present formulary, development of nurse prescribing. Concerns about the inclusion of drugs for use in palliative care - need to flag up if they are licensed for those uses. Nurses should not be prescribing for off-license applications. Some of the large numbers of antibiotics listed could lead to interaction problems. Seek clarification on several questions surrounding eligible nurses for example, on assessment of competence and requirements for updating skills and knowledge. Newly qualified nurses should be excluded until a certain level of experience is achieved. Other issues: need for nurses to be supported by their employers, medical and pharmaceutical colleagues, importance of nurses being offered a full formulary from which to prescribe, reassurance that only qualified children's nurses will prescribe for children.

National Association of Theatre Nurses
Agreed list of POMs. Defer to CSM on the question of antibiotics.

Infection Control Nurses Association
Limit antibiotics to CSM list. Excessive number of drugs for UTI. Concerned over inclusion of Cellulitis.

**British Association for Nursing in Cardiac Care**
May be more appropriate to run training at level II rather than III. With regard to page 55, (6) of Annex D, wished to point out that it appears to omit prescribing for palliative care needs of someone with heart failure.

**Community Practitioners and Health Visitors Association**
Lessons should be learnt from programme for district nurses and health visitors. Ensure consistency of training, provide regular training for health visitor and district nurse returners to practice. Meet commitment to provide annual update training for those involved in the original roll-out.

**Royal College of Nursing: Sexual Health Forum Group**
Pleased that contraceptives are included but question exclusion of Implan and Dianette. Concerned about mechanism for introducing new products to the list. Fear it will continue to be slow/cumbersome. Re antibiotics - nurses should be treated like other prescribers. Some concerns over eligibility/training. Local prioritisation may not be fairly implemented. Eligibility criteria may be too open allowing inexperienced nurses with the right training to prescribe. Also, some nurses feel they are able to prescribe without undergoing further training. Suggest maybe building in minimum level of experience or stating specific areas requiring additional training. Some concerns about two systems of nurse prescriber running alongside each other. On antibiotics, suggest additions to treat GU indications. out.

**Association of Respiratory Nurse Specialists**
Note medicines designed to treat lower respiratory tract have been excluded. Seems illogical that treatment for asthma excluded while nasal corticosteroids which can have systemic impact are on the list. Surprised salbutamol not included. Main thrust of comments is that proposals do not take account of their specialist role.

**Association for Nurse Prescribing**
More rigorous training required than was the case for first wave of prescribing. Robust clinical governance necessary. Concerned that quality of medical practice support is standardised in line with clinical governance. Clear guidelines required re competencies of prescribers and programme of public education. Concerned by inclusion of some items on POM List with limited efficacy eg codeine phosphate, antimicrobials for gingivitis which only give transient relief. Products for otis media and sore throats - often these conditions resolve without need for antimicrobials. Likely that inclusion of these products will feed demand. All nurse prescribers should have access to the BNF. Nurses in palliative care need to be able to prescribe what is needed even if this means CDs. Re antibiotics, shorter list means that patients less likely to get appropriate treatment without delay. Key to dealing with resistance is better education on public health issues and better prescribing practice by everyone - not just nurses.

**British Dermatological Nursing Group**
Skin disease not a minor ailment. Concerned about generalist nurses prescribing in specialist areas. For dermatology, nurses should be trained by a specialist and
supervised practice should be undertaken by a specialist. Treatment for Psoriasis should be included. Super potent corticosteroids should be excluded. Both these and potent steroids should not be prescribable for children. Tetracycline and Minocycline should be included for acne. Education should be standardised across regional govt administrations.

**Community and District Nursing Association**
Number of lessons to be learned, ways devised, to ensure this wave of prescribers is better prepared, supported and more confident in providing safe care. Some queries about whether the period of training would be sufficient, what cover costs would be available. Vital that on-going support is provided by suitably qualified expert. Nurses need to have access to unrestricted access to patient records to ensure safe practice. Concerns that extension of nurse prescribing is an attempt to reduce GP workload by using nurses as cheaper surrogate GPs. There will be financial repercussions with regard to indemnity for individuals and employers. Nurses will need to be paid appropriately for extra training and responsibility. Needs to be greater clarity about who will be independent prescribers.

**B MEDICAL ORGANISATIONS**

**Royal College of Anaesthetists**
Content with proposals.

**Royal College of Physicians (London)**
Recommend that the length of time for which a prescription is given be defined. Consideration should also be made for the provision of a consultation with a doctor prior to a repeat prescription being issued. A process of revalidation of prescribing competence should be implemented. With regard to the list of antimicrobials, the list may require modification on a local level in order to comply with relevant Primary Care Trust policy.

**Joint Consultants Committee**
No objections except to Annex C on oral antibiotics. Administration of the medicines is acceptable with regard to uncomplicated female UTIs. It is not apparent why CSM has excluded dental abscess from the list.

**Medical Protection Society**
Supportive. Only caveat being the need to ensure that in developing the role of individuals, the importance of continuity of care and proper communication between healthcare professionals sharing the care of patients is given sufficient emphasis.

**The National Association of GP Co Operatives**
Proposals will be a valuable part of integrated care out of hours.

**General Medical Council**
Only comment is on a point of principle. No reference to monitoring of introduction of extended nurse prescribing in MLX or on websites. Essential that nurse prescribing is subject to open audit and assessment to ensure both patient safety and
that the extension does contribute to better patient care. Would like some ref to this point to be included in future publications or consultation.

**British Association of Dermatologists**
Mostly relate to prescribing for skin disorders. Dermatological disorders identified as minor ailments but this is not the case and almost all would be better described as common chronic disorders. Diagnosis of skin disorder should be by a doctor before a nurse prescribes. Prescribing of super-potent steroids should be limited to doctors. Concerns about the inclusion of drugs containing sensitisers and three topical antibiotics: neomycin, gramicidin and mupirocin. In particular, the latter should be reserved for MRSA patients only.

**Public Health Laboratory Service (PHLS)**
Extending number and range of professionals who can prescribe antibiotics runs counter to recommendations of professional and government groups. Note with regret that Ministers have decided in principle that nurses should be able to prescribe antibiotics. Do not recommend the wider list considered by CSM. Enhanced surveillance programme should monitor impact on amount of antibiotics prescribed and resistance patterns. Concerns about several of the drugs on the CSM list to which there is resistance.

**The British Thoracic Society**
Include PPD for Mantoux or Heaf test given that BCG is included. Rest of comments mainly concern broadening scope of treatment areas to reflect activities of Respiratory Nurse Specialists. With exception of palliative care, these are o/s scope of consultation. On palliative care, point out that RSNs play key role in care of patients with lung cancer. Anticipate that nurse prescribers in this area will need stronger analgesics on the list.

**Royal College of General Practitioners**
Support in broad terms. Have not seen the details of the courses, which are going to be far more extensive than the current scheme. MCA or any other body acting with or on behalf of DH should not be allowed to ignore the extended training undertaken by doctors in preparation for their prescribing role. For nurses to prescribe safely requires adequate training, support and continuing education. On training, note that it is limited to general aspects and not give grounding in clinical pharmacology and therapeutics. No proposals apparent for national standards defining what clinical training a nurse must have before being considered competent to prescribe. How will anyone know what, within range of eligible prescribing, a nurse is professionally competent to prescribe. Supervised practice period is grossly insufficient. Patients and other professionals should be aware of the nurse's status during this period. Agree CSM list of antibiotics but case for nurse prescribing is relatively weak. On main list, also agree but while accepting inclusion of some CDs it may be desirable sometimes for prescriber and day to day carer to be separate. Chronic disease management not covered. Other concerns: inclusion of topical NSAIDs, not sensible to make diazepam more available, potential to prescribe opioids some of which aren't weak.

**The Medical Society For the Study of Venereal Diseases (MSSVD)**
List of minor ailments includes number of conditions which might be seen as presenting features of HIV or genital tract infections which could be sexually
transmitted. Think it unwise to extend prescribing in the sexual health area unless there are strict guidelines re investigation, follow up etc. All comments are in the context of sexual health (which is not the subject of this consultation) but express concern about use of antibiotics, topical steroids, lack of detail re treatments, competence. Independent nurse prescribing could be deleterious to early recognition of STIs and their public health control.

**British Pharmacological Society (BPS)**
Welcome level of training. With proper training covering pharmacology of drugs and their use as well as diagnosis and management of the conditions, happy with list of drugs.

**Royal College of Physicians of Edinburgh**
Support qualified by various factors: full training, national scheme to allow GP to be kept informed of all POMs patient is receiving, nurse prescribing should not be the administrator of same therapy, more thought needs to be given to legal responsibilities e.g. on the pharmacist or medical practitioner where the patient receives potentially interacting medicine via prescription from a nurse. Key issue must be patient safety. None of the treatment areas are clearly defined. As presently worded this would extend prescribing portfolio of nurses almost ad infinitum. College would not support this without much more careful detailed thought. In palliative care, see major benefits perhaps dependent prescribing to start with but should only be available to specialists. Object to independent prescribing of e.g. gabopentin, sodium valproate. These would rarely, if ever, be initiated by a GP. Minor injuries/ailments section very large and includes conditions which may not be minor and require medical input. Couldn't support inclusion of these without major qualification. Concerned about potential interactions. Urge exclusion of antibiotics. Nurse prescribers should be experienced. Inappropriate to allow junior nurses to prescribe. Lack of emphasis on audit, documentation, uniformity.

**The Royal College of Surgeons of England - Faculty of Dental Surgery**
Feel strongly that the evaluation in relation to diagnosis of oral disease needs re-evaluation. Background info is incorrect. Term dental infection used under indications. This should be more precise e.g. state dental abscess otherwise risk of prescribing systemic antibiotics for other disorders including gingivitis. Inappropriate for nurses to manage aphthous stomatitis. Other concerns re treatments for abscess, candidiasis, gingivitis, stomatitis, inclusion of miconazole dental lacquer. In palliative care, note that dry mouth is not caused by oral candidiasis. Artificial saliva substitutes are in the BNF.

**British Society for Antimicrobial Chemotherapy - (BSAC)**
Unclear how the proposals enhance patient care or make better use of their skills in relation to antibiotics. Concerned there is to be no piloting. Proposals run contrary to Gov't strategies to reduce antibiotic use in minor conditions. Recommend that prescribing of antibiotics should only be extended for lower uri and bacterial vaginosis and only in respect of a limited number. Nurse practitioners should be supported in a role to encourage realistic public expectations by providing initial consultations on minor infections for which antibiotics are unnecessary. If proposals accepted, recommend a national programme of training, continuing development, monitoring and arrangements for withdrawing the right to prescribe.
British Medical Association - (BMA)
Support the concept of nurse prescribing but would prefer a more gradual approach to these proposals i.e. extending existing rights to nurses in primary care, recognising specialist skills (which could include a right to prescribe at a higher level within the specialist area). Prescribing is a more onerous responsibility than supplying in response to a patient request. Unconvinced that nurses can be safely trained to prescribe at the level suggested within the timescale set out. Extension should facilitate nursing skills rather than seek to provide an inexpensive substitute for medical skills which could expose nurses and patients to risks. Concerns that nurses will be pressurised into training and the implicit assumption that diagnosis and treatment of minor illness can be delegated to nurses. Believe any significant expansion of nurse prescribing will be impracticable until there are adequate numbers of nurses to provide basic care. Also concerned about funding (re prescribing costs), clinical responsibility, awareness of patient information, inclusion of antibiotics, topical NSAIDs and a range of other drugs (many in palliative care).

Royal College of Psychiatrists
Would like to see greater clarity from MCA about the territorial effects of proposals such as this i.e. confirmation that each of the 4 Health Depts could decide separately whether to implement the proposals. Concerns about sufficient training for nurses to recognise side effects, interactions of medicines. Q If it is wise re non-inclusion of opioids, to allow prescribing of one half of what is often described as a cocktail of drugs. Recommends that only generic names are used for the medications prescribed.

Association of Medical Microbiologists
Concerns about extending nurse prescribing to antibiotics.

The Royal College of Ophthalmologists
Supportive if there are protocols in place to assist nurses with decision making process when treating named conditions.

Faculty of Family Planning and Reproductive Health Care - Royal College of Obstetricians and Gynaecologists
Clarify that PGDs are being retained. Support wider list of antibiotics. Would like list of POMs to be widened to include drugs for STIs. Re IUDs - clarify if this just relates to prescribing or covers fitting as well. Include Implanon - there is a valid training course for fitting it. Exclude Ovran and Norinyl-1. Unclear where training the nurses will have undertaken in the treatment areas. Assume that practice with the mentor will be speciality based. Want a clause to allow senior nurses to continue practice without having to start a complete course of training.

The Association for Palliative Medicine of Great Britain and Ireland
Concerned by proposals. Do not consider that training period would be in any way equivalent to existing palliative care specialists. Would encourage prescribing in palliative care but only by senior experienced nurses. Educational process needs to be more rigorous. Feel inclusion of palliative care with other treatment areas show fundamental misunderstanding of the nature and complexity of palliative care and the list of palliative care drugs is far too limited, arbitrary and facile.
Royal College of Paediatrics and Child Health
Support prescribing in paediatrics in principle. Wish to see greater clarity re independent/dependent prescribing. For example, would presume that in palliative care, a child's specialist doctor would provide initial advice about which drugs were appropriate. Expect anyone prescribing for children to have had specific training on paediatric prescribing, as there are issues peculiar to children e.g. particular formulations. In terms of content of the training would expect nurses to have same knowledge and understanding expected of medical staff. Seek clarification on how, and by whom, competency to prescribe will be assessed, whether drugs and listed indications are licensed uses and if nurses will only be able to prescribe using oral medications. Many drugs listed do not have established paediatric doses and confusion may arise if the doses are different from the widely used publication "Medicines for Children". Wider availability of antibiotics will need to be monitored - seems contradictory to recent DH report on the issue. Detailed comments on Annex D focussing on paediatric issues.

The British Dental Trade Association
Concerned about nurses prescribing oral antibiotics and pain relievers. Could mean the early signs and symptoms of oral cancers go unnoticed. Diagnosis is still a specialised activity even in general dentistry.

The College of Optometrists
Notes that prescribing rights would be extended to area of ophthalmic disease. Not clear what training nurses will undergo. Given amount of training proposed, likely that only one day or less would be for ophthalmic prescribing. Takes much longer to become proficient in use of equipment necessary for diagnosis of anterior eye conditions. Seems strange that optometrists can't routinely prescribe therapeutic medicines given their training specifically relating to the eye but MCA propose to allow nurses to prescribe antibiotics, 2 antihistamines and 3 mast cell stabilizers based on 1 day or less training. Optometrists have been recognised as future prescribers and are currently preparing an application for independent prescriber status that will propose a comprehensive training programme leading to formal certification and registration. This will be a lot more than the 25 days proposed for nurses of only which a fraction will relate to treatment of ocular disease.

Specialist Advisory Committee on Antimicrobial Resistance (SACAR)
Sacar is in no doubt that one of the main factors influencing the spread of resistance is inappropriate prescribing of antibiotics. Committee believe that systemic antibiotics should be excluded from the nurses' list or at least restricted to a very few situations. CSM list of antibiotics includes conditions which cannot be classified as minor and conditions inappropriate for prescription of antibiotics. SACAR considers they need medical supervision. Only two conditions could be appropriate for nurse prescribing because they can be easily and accurately diagnosed: Urinary tract infections and bacterial vaginosis. Even so, there would still be concerns and prescribing should be within tight guidelines.

Hospital Consultants and Specialists Association
Support proposals but some reservations over wider list of antibiotics in terms of development of resistance and need for medical review of some of the indications.
C
PHARMACEUTICAL ORGANISATIONS

The Royal Pharmaceutical Society of Great Britain
Patient safety of paramount importance. Must be absolute clarity about how competence to prescribe is defined and ability to diagnose/manage conditions. Q of level of clinical supervision/regulation in the private sector. Difficulties for pharmacists identifying area in which nurse authorised to prescribe. Pharmacists should have same list available. Liability issues need addressing. Crown said that antibacterial antibiotics should not normally be available to new prescribers but CSM list is more appropriate than the wider list. What resources will be available for nurses to choose appropriate P and GSL products. Prescribing of these products could impact on drugs budget. Also q about prescribing resource for nurses. BNF might seem appropriate but would need changes also, written primarily for doctors and pharmacists who interpret it in light of extensive education and training. Detailed comments on Annex D eg: dental infection specialist area of practice, some analgesics on list not available to dentists, only chloramphenicol for eyes, prescribing in pregnancy, seek expert opinion on dermatology treatments. Palliative care section contains drugs and routes which are not licenced. Concerns about inclusion of potent topical steroids.

The National Pharmaceutical Association
Need a system to be in place so that pharmacists and the PPA can easily identify those nurses eligible to prescribe. Would like to meet to discuss this. Nurse should only be able to prescribe within competencies and would like this to be a legal requirement. Support limited range of antibiotics. Some of indications for antibiotics in the wider list are not consistent with the proposed treatment areas. Don't consider gingivitis, sinusitis, cellulitis and chronic skin ulcers to be minor ailments. Support nurse prescribing of Sch 4 Cds on the list in palliative care.

Company Chemist Association
Antibiotic prescribing should take account of concerns about resistance. Suggest a step-wise approach initially limited to CSM list with referral to the GP as a second step. However, feel that if appropriate training has been undertaken nurses should be able to prescribe from the wider list. Prescribers should undertake continuing professional development. Must be a means of ensuring pharmacists can tell if a prescription has been written by a nurse with the necessary qualification. Community pharmacies need easy access to an up to date list of agreed reimburable NPF.

Primary and Community Care Pharmacy Network
Eligibility for prescribing should be based on competence as well as local need. Initially, nurses selected should have additional qualifications. Choice of POMs should be limited to most effective. Several products not suitable: topical antibiotics and NSAIDs. Suggest adding: inhaled salbutamol, more oral NSAIDs (not specified), GTN, WFI. CSM list of antibiotics prefered.

Scottish Pharmaceutical General Council
Needs to be an identifier to allow prescriptions to be dispensed by pharmacists with confidence. Range of drugs causes concern - should be effective and VFM. Inappropriate therefore to include items such non-steroidal inflammatory agents.
Oppose extension of nurse prescribing to palliative care and CDs. Prefer CSM list. Need up to date info for each patient and training should highlight need to maintain records.

**Paediatric Chief Pharmacists Group**
Not clear within proposed definition if nurses eligible to prescribe in paediatrics need to hold and maintain registration with a statutory body in a child health discipline. If paediatric prescribing is to be included important that experienced paediatric pharmacists have an opportunity to contribute to the development of appropriate training programmes. Will nurses be able to prescribe off-label? Concerned that the palliative care list may be restrictive and would support inclusion of 5HT3 and Haloperidol. CSM list of antibiotics supported with addition of co-amoxiclav for treatment of bites and minocycline for acne.

**Guild of Healthcare Pharmacists**
Proposals do little to assist provision of secondary care. Reservations around the practicalities and would have preferred to see a consultation on supplementary prescribing first. Have had some experience of making antibiotics available under PGDs. On this basis no reason for not including all the antibiotics on the nurse list. Any restrictions on availability from the list would be via local formulary arrangements applicable to other professionals. Should be potential for inclusion of co-amoxiclav for human bites. CDs will need to be considered in order to make prescribing in palliative care effective. Home Office agreement to an amendment to the Misuse of Drugs Regs should be sought as soon as possible. NPF would be most appropriate reference for nurses. Amount of training seems appropriate but would need to see details of the curriculum before making final comment. No costs for staff cover and could be problems assigning a prescribing mentor. Questions how the nurse prescriber, the medicine and the indication going to be linked. Also raises issue of self-prescribing or prescribing for family/friends not under the direct care of the prescriber concerned. In the interim, suggest issuing guidance similar to that provided by the BMA. Supports definition of eligible nurses but guidance will be needed on how pharmacists can recognise prescribers. Who will assure competence of the practice supervisors? What will be the procedure to take if a new prescriber is prescribing inappropriately?

**Neonatal and Paediatric Pharmacists Group**
Concerned proposals will have little impact on secondary care. Look forward to supplementary prescribing. Not appropriate to treat antibiotics separately - principles of prescribing are the same as for other POMs. Co-amoxiclav is recommended for bites but not in the list. Has issue of pharmacist recognising eligibility of a nurse to prescribe been thought through. Main concern is issue of paediatric prescribing. Many products used outside the SPC and want to know how this provision will be met. In relation to this point, would be interested in training structure and appreciate further consultation.

**College of Pharmacy Practice**
Will training period make nurses competent to prescribe? Not convinced that extending prescribing to antibiotics is advisable. Access to info to allow safe prescribing needs to be confirmed. Issue of pressures from industry on new prescribers. Continuing professional development is key.
D

SELECTION OF COMMENTS RECEIVED FROM OTHER ORGANISATIONS

British Heart Foundation
For palliative care, there is a discrepancy between Annex B (proposed list of POMs and Annex D in relation to hyocine butylbromide. Ineffective when given orally and that route should be removed from Annex B. Concerns re adequacy of training, use of baclofen and dantrolene, knowledge base for antibiotics and antifungals (generally as well as palliative) Those using aminoglycoside containing aural preparations must be able to recognise perforated ear drum.

Marie Curie Cancer Care
Would extend definition of nurses eligible to prescribe for specialist palliative care needs. Nurses would be significantly limited in ability to usefully prescribe in pain management situations when they have access to co-analgesics but not opioid drugs.

British Menopause Society
Concerned about the exclusion of the menopause from the treatment areas. Norethisterone Oenanthate is an injection not oral.

University of Wolverhampton
Disappointed at prospect of two formularies and exclusion of certain nurses eg practice, school, mental health.

Wyeth Laboratories
PPIs for heartburn should be included and minocycline for acne.

Novo Nordisc Ltd
Proposals welcome subject to training caveats. Consider addition of local HRT for atrophic vaginitis. Management of chronic diseases should be considered.

Family Planning Association
Supportive but some disappointment that nurses were not given access to all medicines. Must be adequate funding to ensure successful implementation. Vital that process will allow for flexibility so that new medicines can be added quickly to the list. Sexual health is more than contraception. Drugs and treatment relating to genitourinary medicine needs to be included.

National Eczema Society
Welcome prescribing of antibiotics for management of acute infection.

Skin Care Campaign
Most skin diseases not minor ailments. Appropriate training for nurses in dermatology almost completely lacking. Proposed training would not equip nurses to diagnose accurately. Need specialist training and until this is available must distinguish between diagnosis and treatment. Reservations about inclusion of some super potent topical steroids and exclusion of treatment for psoriasis.

Acne Support Group
Wants to know why Dianette hasn't been included for acne. Concerned that nurses receive adequate training in management of acne. ASG well placed to offer such training. Would wish it to be made clear that scarring is a possibility in all acne cases.

**Whitehall Laboratories**
A complimentary activity to reinforce the objectives of the proposals is consideration of suitable OTC medicines that might be recommended by nurse prescribers.

**Independent Health Care Association**
Prescribing rights should be exercised only by nurses able to express specialist competencies. Large gaps in formulary - suggest it should include all products available to doctors in the four treatment areas. Support wider list of antibiotics. The CDs on proposed list should be available for prescribing across the treatment areas. Close association of POMs with pre-determined conditions should be reduced and nurses allowed to select most appropriate medicine for any condition they identify. Clear and simple measures should be put in place to facilitate expansion of the new formulary. Nurses working within the independent sector should be able to follow the same agenda as those working in the NHS.

**SELECTION OF COMMENTS RECEIVED FROM NHS PRIMARY CARE GROUPS AND TRUSTS**

**Bedfordshire Health Authority**
Generally, training period is inadequate. Should be a national definition of nurses who are to prescribe. Local decisions on prescribing will cause confusion and will not automatically be transferable outside the locality. Definition of nurse prescribers in palliative care should be more clearly defined and training should be restricted to those with a degree or diploma in palliative care. List of drugs is too broad. Narrower list would Help nurses to become more familiar with the drugs. Eg given of including PC4 while it is acknowledged in the text that it is not as effective as Levonelle. Legislation should make clear that only qualified Macmillan nurses should be allowed to prescribe palliative care drugs. Has some queries about the list of palliative care drugs which it is proposed would be used outside licensed indications. Also would not be able to prescribe total care package - no CDs are included for pain relief. Finally, no antibiotics should be prescribable by nurses.

**Dartford and Gravesend NHS Trust**
Concerns about extension to P and GSL as well as POMs. Value of treatment areas in hospital minimal. Conditions to be treated doesn't include oral contraception and vaccinations except in health promotion. Most concerned about list of antibiotics and would be even more so if the list was the wider one considered by CSM. Also concerns over depth of knowledge achievable in 3 months training period. Identifies number of POMs which they consider should only be prescribed within guidelines plus others not suitable for frontline treatment: amphotericin, fluconazole, frurbiprofen, isotretinion. Nefopan should be taken off list.

**Kirkby Primary Care Group**
Remove list of topical NSAIDs which are of limited clinical value. In palliative care, nurses should be advised that they are using drugs for unlicensed indications. WFI could be included and Glycopyrronium Bromide. Support CSM list of antibiotics.
Shepway Primary Care Group
Topical NSAIDs should be omitted. CSM list of antibiotics should be adequate. Antibiotics list for eye infections too extensive, should only include chloramphenicol and fusidic acid. Combination antibiotics/steroids for eczema should be deleted. Topical preparations for impetigo except mupirocin and fusidic acid should be deleted.

Wakefield West Primary Care Trust
Suggest treatment for asthma is added to the list. Welcome current list of antibiotics with addition of amoxycillin and erythromycin for treatment of infective exacerbations of COPD and Asthma. Training should be modular to reflect specialisms, not clear whether existing prescribers would be credited for current qualification and therefore require shorter training. Support inclusion of replacement costs for backfill arrangements.

Wychavon Primary Care Group
Proposed scheme unrealistic and unmanageable. Nurses should only gain prescribing rights in their speciality. Disappointed that supplementary prescribing wasn't considered first as most practices running specialist clinics eg asthma would benefit. List of medicines too long and should be restricted. Concerns about training being rushed through, inadequate. Needs to be adequately resourced. On product choice, dismayed that nurses will gain right to prescribe products less suitable for prescribing and that GPs have been encouraged not to prescribe eg topical NSAIDs. Ophthalmic product range inappropriate - should only have a couple of choices to ensure patient is referred to a doctor if there is no rapid response. Concerns re topical steroids. Agree CSM list of antibiotics.

Northamptonshire Health Authority
Nurse prescribing must become integral part of clinical governance. Concerns variation across HAs will lead to inequities in treatment and access. Range of drugs excludes nurses in specialist roles apart from palliative care. Practice nurses may not feel prescribing enhanced sufficiently to justify training period. On list, difficult to ensure prescription written out for an indication in the NPF. Generally, too much choice. Many HAs/PCTs restrict range available to ensure VFM and cost-effective use of resources. Reservations about opening up antibiotic prescribing. CSM list valid attempt to restrict antibiotics but difficult to ensure prescription written for amoxicillin was for lower UTI. Need protocols/guidelines to be in place. WFI should be added. Questions whether it is appropriate for a nurse to initiate therapy with proposed range of drugs in palliative care.

City Hospital Sunderland
Agrees with eligibility. Would like local universities to teach course thereby providing quicker access for the staff they have invested in. Welcome list of POMs but want to see many more additions eg in field of A&E, Renal depts. Wider range of antibiotics should be added to list with monitoring and control being exercised locally by appropriate depts.

Canterbury and Coastal Primary Care Group
Topical NSAIDs should not be included because of doubts over efficacy. CSM list of antibiotics preferred. Various concerns about antibiotics for ophthalmic, aural, nasal and/or external use. Questions the inclusion of flurbiprofen, sodium valproate, cimetidine.

**Soho Walk-In Centre**
CSM list of antibiotics and indications too restrictive. Wider list reflects antibiotic PGDs. Chest infections not included but is common presentation at the clinic.

**Wyre Forest Primary Care Trust**
Proposal to include all P and GSL includes products which are BNF less suitable for prescribing. Questions inclusion of topical NSAIDs which are on the Prescription Pricing Authority list of drugs of limited clinical value. Why such a wide range of products? Would only include chloramphenicol and fusidic acid for infective conjunctivitis. Prefer CSM list of antibiotics apart from nitrofurantoin because of toxic effects. Need resources for backfill. Would prefer rolling programme over longer period of time. If nurses have already undertaken advanced training courses allowances should be made for them.

**Mid-Hampshire Primary Care Trust**
Concerns re choice of products - some of which are of "limited clinical value". Generally supportive if there is a benefit shown for the patient. Other concerns about lack of clarity re training and practicalities involved. Prescribing needs to be via practice prescribing systems.

**Ashford Primary Care Group**
Supports eligibility definition. Topical NSAIDs should be excluded. CSM list of antibiotics preferred with addition of co-amoxiclav for bites. No need to include vaccines - covered by PGDs.

**SELECTION OF COMMENTS FROM INDIVIDUAL NURSES**

- CSM list of antibiotics preferred. Family planning qualification should be required for prescribing contraceptives. Eligibility should be decided at national level and restricted to those practising at degree standard. Practice Nurse

- Regrets another formulary. Nurses should use BNF within professional competence. CSM antibiotic list would be ok if otitis media and sinusitis were included. Practice Nurse

- Only useful for certain nurses. Concerned proposed training might be inadequate as nurses will also need to be able to diagnose. Nurses shouldn't be forced into prescribing by employers. Health Visitor

- Working remit is far wider than proposed prescribing items. Nurse Practitioner

- No mention of recognition of prior learning. List for minor injuries wholly inadequate. One of the most obvious missing is subcutaneous lignocaine for
closing wounds. It will still be necessary to use PGDs for majority of medicines. Minor Injury Nurse

- Definition of eligible nurses should be those who specialise in a particular area. They should have protocols for the drugs prescribed. A lot of medical training will be required before nurses could prescribe antibiotics. Nurse Specialist

- Excellent idea. Will improve patient care and empower nurses to become more effective in their prescribing. District Nurse

EXAMPLES OF COMMENTS FROM DOCTORS AND PHARMACISTS

- Might be helpful to have a diagnosis on prescription form so that checks can be made that drug is being prescribed for an approved condition. Will specialist nurses have an unique identifier to ensure prescribing in appropriate area? Will common minor illnesses be open for all nurses to use. Pharmacist

- To prevent adverse reactions between drugs prescribed by the patient's GP and a nurse also interactions with conditions, need to have single electronic prescribing record. Suggests GP systems are used because they could be readily modified and would be willing to pilot a project. Doctor

- Proposals seem reasonable. Limited list of antibiotics fine. Questions inclusion of azithromycin and claritromycin. Erythromycin is much cheaper except where there is a clear case of intolerance. Doctor

- Hopes prescribing rights will now soon be extended to pharmacists. Common training programme may not fill needs of different nurses, also who will do the training and fund it? POM list is too long, if choices were limited training might be easier. Not in favour of antibiotics containing dermatological products being included because of resistance. Pharmacist

- Delighted with proposals but why has HRT been excluded. Doctor

- Concerned about prescribing haloperidol in palliative care for restlessness and confusion. Combination of potentially sedative drugs can lead to over-sedation. Nurses will need adequate training in the sedative effects of these drugs. Doctor