

Group A – Multi-Disciplinary

Communication – secondary & primary care – consultant / CPN

- Skills
- Nurses (pharmacology)
 - Pharmacists (consultation skills)

Competency

- polypharmacy
- patient centred care / holistic

Stopping medications / doses

Skill mix / joint CPD

Group B - Depression in primary care linked to crack cocaine

Second line as a first line – SSRI therapy

Move to prescribing antidepressant for crack cocaine users

Education important use Fluoxetine to be avoided, Citalopram helpful. Anxiolytics effective (not spc)

?drug of choice in renal impairment

Is there a current evidence base

PTSD & Homeless – engagement of this group

Role of prescriber in heavy skunk users – Olanzapine, Aripiprazole.

SIGN (Scottish NICE) – protocols

CBT recommended by NICE, 3 levels of depression

When to offer pharmacological intervention / evidence base

Mild depression

Rating scales - HAD

- Hamilton depression – not advocated in SMS
- Becks scale - “

Research – Dunn –

PTSD + adjustment disorder

Peer supervision

Websites

HCV treatments – helping patient through treatment i.e. antidepressant (protocol)

Maudsley prescribing guidelines – psychiatrist use this, useful tools

BNF – contact pharmacist

Group C – Trust wise equality

Issues

1. grading – 6 to 8a
2. pathways
3. No central guidelines from DoH
4. Disparity CPD & SP + IP
5. Medics not totally on board, reluctant to relinquish control.
6. Disparity in course structure, not enough focus on MH
7. Move across Trusts
8. Clear guidelines from NMC
9. Access to NMP course and ongoing training
10. Not utilising resources effectively i.e. staff skills & funding for previous training
11. Physical health checks who is responsible?

Group D – Clozapine & CMPs

Key concerns:-

1. Safety
2. Has to be SP
3. Nurse has to be involved in all of the CMPs
4. Has to assess / know all patients
5. May not be care co-ordinator
6. Access to IP – info sharing
7. Capacity to follow up
(two within the group experienced these problems)

Have tried:-

1. limiting it to those that are care co-ordinated
2. Discussed with RMO & Managers – no outcome or support
3. Clinical supervision
4. Discuss with prescribing lead

Ideal outcome:-

1. Improvement in efficiency of Clozapine prescribing
2. Improvement of safety
3. Avoid prescribing for patients not known to the prescriber
4. Adequate support systems
5. Time to follow up
6. More flexibility with CMPs

Help & Hinderance:-

1. Not knowing all patients
2. Management / support – lack of!
3. May have S.W as care co-

Ideas to reach solution:-

1. Priority
 2. Good supervision / support
 3. Reduced caseload – restructured
- * Sufficient numbers of NMPs within practice to provide efficient service. No solutions found – still planning / pilot project.

Group E Why are prescribers not fulfilling role?

Who leads in NMP? Within Trusts

Stakeholders?

- NMP themselves
- Head of nursing
- Medics / Consultants
- Service users
- Lead pharmacists
- Director of services (with understanding of issues)

Who has most influence...

- Director of services
- Head / Director of nursing
- Research / evidence base
- Medics?? Should they

Barriers to prescribing

- Medics – supervising / supporting etc
- Director of services / heads of nursing not understanding of training or strategic development issues
- Pharmacists
- NMPs – sometimes too passive (in isolation)
- Money / finances – recognition

Breaking down barriers?

1. Medics / Consultants?
 - Part of process as DMP, supervisor etc
 - Part of post prescribing CPD
 - Should be part of JD??
 - Part of NMP policy development
 - “Educating Drs re NMP”
 - ?institute of psychiatry – target at this level?
 - Attending clinical meetings / ward rounds
 - Joint working
2. Director of services / Leads of nursing
 - Commitment for support
 - Strategic development commitment – when signing off courses?
 - More understanding of legal & governance aspects.
 - Need more evidence base in MH
 - Development of nurse led clinics as starting point.

3. Pharmacists
 - o Education & understanding of NMP course
 - o More liaison with Directors of service i.e. Strategic development
4. NMPs
 - o Develop leadership skills
 - o Provide / promote evidence base
 - o Clearly defined CPD training
 - o Network ? NMP webpage for prescribers in Trusts & Nationally

Group F Implementing Independent NMP

Concerns – Acceptance / approval by Trust / Consultants stakeholders.

- involve influential professionals
- Executive – down move

Medical Supervisor engagement

- Benefits of NMP
- Identification of need to service
- Not replacement – enabling / added value / innovation

Feeling “threatened”

- understanding roles / multidisciplinary working

ideal outcome

- Network approach – team / coordination / specialist role
- Enhanced “specialist” focus on own area of practice preparation prior to non-medicational prescribing
- Tailored courses to enable skills / theory deficits

Group G Strategy for NMP

Concerns:

Lack of strategy / forward planning
 Understanding of the role difference
 Between independent / supplementary
 Managers & nurses not well informed
 Missed opportunity / targeted the wrong areas

Shared Experience:

Policy in place, no strategy / targets to achieve / conflict with current targets / activity. *Need to harmonise / compliment activity / targets / NMP.

Tried so far:

Trustwise – no consensus, difficult to achieve role.
 Care groups
 Patients / diagnosis

Solution	Directorates – maybe focus on specific Forum provides opportunity Develop local interest / champions Gather evidence to support NMP
Ideal solution	National approach linked to NMP in mental health

Group H - Barriers to Independent Prescribing

1. Policy development – specialisms in mental health
2. resistance from consultant psychiatrists & pharmacists including leads
3. Lack of local formulary
4. No structured medical supervision
5. No positive lead for non medical prescribing
6. Not able to independently prescribe unless having done supervised supplementary prescribing
7. supervision net available - ?group supervision
8. Off licence medication
9. Psychopharmacology course required
10. Pay bands – JD
11. Medical model – defensive professionals

So far,

Management support

Safeguards – competency framework

Probation of 6 months

Cons. Support

Ultimately IP

Solution

SHO type role in terms of IP

Continuing training and development

Nurse led clinics as IP

Follow USA

Group I – Development (All of us)

No relevant champion (no medics) / lead for NMP

I for every Trust (a passionate proactive lead)

Difficulties with policies / framework.

?Personal ownership / own destiny

Reconfiguration of management

Clear pathways including CPD

? Medical staff reservations (?threatened – where will they work)

? Not valuing ourselves

Nagging the wrong person

Do it yourself
Use each others ideas
Tools – books / audit / stamp / drugs
Good ideas
Conferences / networking psychopharmacology minimum 3
moths period of evidence (part of pathway)

Group – J – Moving forward from supplementary prescribing to independent prescribing

Developing professional relationships
Getting the hierarchy on side – agreeing a policy
Developing a strategic plan

Nurses owning the challenge – what motivates – NMP
forums/groups, more money, seeing it working, NMP champions

Business plan

Believing in our competency

Identifying areas of need – getting managers on board

Group L – Policy & Development

Does this include CPD?
Planning, mentorship...

Limited consistency across country - equal qualification?
Depth of knowledge
Ability to practice
- Hinderance –
professional
jealousy!

Have spent significant amount of time planning policy / or asking
for policy

Directorate of Trusts – should be active in helping formulate
policy

Collective body of NMP should be at forefront of policy
development

Hinderances: jealousy
Experience – being questioned
Time

Pharmacists (some)
Medics (some)
Management (some)
Peers (some)
No infrastructure
Patient expectation / agenda