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Nurse prescribing in adult social care

Evidence review

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Summary

Overview

Nurse prescribers are trained and registered health care professionals qualified to prescribe medications within their clinical competence. Prescribing includes assessment, diagnosis, prescribing of medications, and the clinical management required for the individual.

Particular to adult social care, there is no clear data on the number of nurses working in social care who either have a prescribing qualification or are using it. Furthermore, there is a lack of research on the evidence for nurse prescribing in adult social care in the UK.

Why we did this research

In March 2026, the Department of Health and Social Care (DHSC) commissioned the King's Fund to review evidence on the impact of nurse prescribing in adult social care and community-based settings, including primary care and community health services. The evidence review aims to clarify what is known about the benefits and challenges associated with nurse prescribing in adult social care and how findings from wider community-based care can be applied to adult social care settings. The findings will help to inform the evaluation of DHSC funded pilot scheme to upskill and increase nurse prescribing capacity in adult social care. The review aimed to address the following questions.

- What is the evidence base on nurse prescribing in adult social care?
- What is the evidence for nurse prescribing within community-based care settings, including primary and community care?
- In what ways can the evidence on nurse prescribing in primary and community care be applied across adult social care settings?

What we did

We conducted a review of literature based on an agreed eligibility criteria. The search included studies in the UK, from 2006 onwards. The year 2006 was chosen because this was the point in time when nurses were allowed to prescribe from the full British National Formulary within their competence. After screening and analysis, 17 studies were selected that met the criteria. Data was extracted from the studies and grouped into narrative themes.

We conducted interviews with six stakeholders with extensive experience in nurse prescribing within adult social care, at both national and provider levels. Three themes identified as being important to effective nurse prescribing. The themes were presented to the stakeholders to test

their applicability and transferability to adult social care. These included strong governance and safety processes, ongoing support and continuing professional development (CPD) opportunities, and effective interprofessional relationships.

What we found

There were no studies on the impact of nurse prescribing specifically in adult social care. Most of the studies identified in the review were within primary care settings. A few studies integrated nurse prescribing in people's homes and care home settings within their wider research.

In settings where nurse prescribers were able to use their qualifications effectively, they were more likely to have job satisfaction and increased self-esteem and saw the benefits of prescribing for their role and the people who use care. However, prescribing practice varied based on seniority, length of experience as a nurse, employer support, and care setting.

Participants reported that nurse prescribing had a positive impact on their practice and services. It enabled them to provide holistic care and complete episodes of care without waiting for a GP review. For community nurse prescribers, delivering timely care was particularly important in reducing the risk of deterioration among people drawing on care.

Participants also identified multiple barriers to effective nurse prescribing. First, most nurse prescribers reported increased workload and responsibility, which left little time to address individuals' complex health needs. Second, there was a lack of trust between social and health professionals who did not understand the prescribing competence of nurse prescribers. Third, community nurse prescribers were more likely to report limited access to GP records and having to work in silos.

The findings suggest that organisations need to provide the right infrastructure and working conditions for nurse prescribers to make full use of their prescribing skills. The infrastructure includes strong governance and safety processes, ongoing support and CPD opportunities, and the ability to build interprofessional relationships.

Insights from stakeholders

The stakeholders confirmed the lack of research on nurse prescribing in adult social care. They attributed this to limited awareness among health and care professionals of nurse prescribing and its benefits in adult social care.

They were clear about the value of nurse prescribing in adult social care. For example, nurse prescribers have close relationships with the people who use care, which is important for identifying deterioration and responding as needed; they can provide timely care without waiting for GP input and can therefore reduce the need for hospital services. The stakeholders reported that these advantages also benefited the wider health and care system – for example, reducing GP referrals and avoidable hospital admissions.

All stakeholders agreed that the themes identified in the literature review, even when they were extrapolated from studies that also covered community health services, were equally important to creating the right infrastructure and working conditions essential for effective nurse prescribing in adult social care.

However, they noted key differences in how these themes were experienced in social care.

- Governance structures differ between providers, as providers vary in size and resource availability – from larger chains to smaller independent providers. These differences influence the governance in place and how nurse prescribers work.
- Continuing professional development can be resource intensive for some providers who have limited resources. Inadequate professional development can have an impact on the ability and confidence of nurse prescribers to prescribe safely.

The stakeholders raised other challenges particular to nurse prescribers in adult social care:

- The cost and inconsistent mechanisms in funding for prescription pads (forms used by nurse prescribers to prescribe medications) between health and social care.
- Duplication of roles with NHS community nurses who also provide services to residents of care homes with nursing (for example, advanced nurse practitioners already working in social care settings).
- Variation in how GPs work with care homes, and inconsistent approaches in primary care to nurse prescribers accessing GP records. For some stakeholders, lack of access was linked to the lack of trust those working in health and social care.

Over time, these challenges result in nurse prescribers not fully utilising their prescribing qualifications.

Implications for policy-makers

There needs to be consistency and increased funding with specific research priorities to help build the evidence base for nurse prescribing in adult social care. The research should include people who us care, and providers, to get a better understanding of their experiences.

Integrated care boards (ICBs) should consider a system-wide approach to developing models of nurse prescribing and infrastructure that addresses the multiple challenges discussed by stakeholders (as discussed above). Integrated workforce planning and adequate resourcing of health and social care at system level can be enablers for developing successful adult social care prescribing models. Stakeholders noted that a system-wide approach can:

- enable better integration between health and social care and how governance structures for nurse prescribing could look for different providers, especially small independent providers. The governance structures could help provide greater consistency in access to nurse prescribers, and update the records of people who draw on care
- address fragmentation between health and social care and duplication of roles.

A system approach can also help ICB leaders to consider nurse prescribing training, support and CPD in adult social care as part of the wider health and social care workforce – and not in isolation.

National bodies such as the DHSC can support a system-wide approach to nurse prescribing in adult social care by developing national guidance for ICBs on governance, information-sharing, prescribing infrastructure and workforce planning.

Finally, policy-makers need to be clear about what nurse prescribing in adult social care is expected to achieve, for whom and in what settings, also considering the diversity of providers and the resources available to them.

Limitations of the review

The included studies were conducted at different points in the development of nurse prescribing policy, including the early period (2006) after nurses gained access to the full British National Formulary, and later stages, when prescribing became more embedded in primary care. Despite these changes, many of the barriers identified remain relevant today.

01 Introduction

Nurse prescribers are trained and registered health care professionals qualified to prescribe medications within their clinical competence. Prescribing includes assessment, diagnosis, and the clinical management required for the person requiring care – including prescription of medication. Training to become qualified as a nurse prescriber should be undertaken with an education provider approved by the UK's Nursing and Midwifery Council (NMC). Nurses represent the largest proportion of non-medical prescribers in the UK. The UK also has the most extended nurse prescribing rights in the world. The aim of nurse prescribing, from its inception, was to improve care and reduce GP workloads (Griffiths and Courtenay 2022; Courtenay 2008; Beckwith and Franklin 2007).

A recent report by the Nuffield Trust on independent nurse prescribing shows that the number of nurses and midwives with an independent prescribing qualification registered with the NMC has increased from 47,595 in March 2020 to 69,061 in March 2025 (Julian *et al* 2026). Many of these professionals are nurses. The increase in the number of nurse prescribers and scope of practice over time mirrors the trends of increasing demands on the health and care system from people living longer, and with more complex health needs (Carey *et al* 2025; Dunn and Pryor 2023; Courtenay 2018).

There are three main types of nurse prescriber.

1. Community practitioner nurse prescribers (CPNPs): These are nurses who have completed the NMC's Community Practitioner Nurse Prescribing course (V100 or V150) and are registered as a CPNP with the NMC (Royal College of Nursing 2021). They are qualified to only prescribe from the Nurse Prescribers' Formulary for Community Practitioners (National Institute for Health and Care Excellence n.d.).
2. Nurse independent prescribers: These are nurses who have completed an NMC course (V200 or V300). They prescribe independently within their competence and expertise.
3. Supplementary prescribers: These are nurses who implement an agreed specific clinical management plan (CMP) with the person's consent. The CMP is developed by the nurse independent prescriber working with the supplementary prescriber, and it contains specific details of the diagnosis, prescription dose and frequency, and benefits and limitations of the prescribed medication.

Nurse prescribing has seen significant advances in prescribing education and prescription scope from the British National Formulary (BNF) over the past two decades (Dunn and Pryor 2023; Courtenay 2018). Some of the significant policy changes include the 2006 regulation, which expanded nurse prescribing from a limited formulary to that of the full BNF within their competence. The regulation gave nurse prescribers more autonomy and extended their ability to prescribe for a wider range of conditions (Secretary of State for Health 2005; Courtenay 2000, 2018). In addition, in recent years, there have been major changes to training standards,

practice, and the governance framework for nurse prescribing in England. For example, all prescribing programmes and practices must abide by the Royal Pharmaceutical Society Competency Framework. In addition, the prescribing standards 2019 were updated in 2023/24 and training requirements have changed, including removing the three-year post registration experience prerequisite to do the training, and expanding the range of professionals who can provide supervision during training (Nursing and Midwifery Council n.d.).

Nurse prescribing in adult social care

Data from a Skills for Care report (2026) shows that in 2024/25, there were an estimated 35,000 registered nurse filled posts in the adult social care sector in England. Most of the nursing posts are in care homes run by independent social care providers, and around 1,700 were working for independent non-residential care providers. But there is no clear data on how many of those nurses either have a prescribing qualification or are using it (Skills for Care 2025; Department of Health and Social Care 2023). Furthermore, in comparison to other parts of the nursing workforce, the evidence for adult social care nurse prescribing is disparate and difficult to identify and analyse (Nuffield Trust 2026; Mendes *et al* 2024).

The Department of Health and Social Care (DHSC) is currently running a pilot scheme funding nurses across six integrated care boards (ICBs) in England to undertake an NMC-approved prescribing qualification. The aim of the pilot is to upskill adult social care nurses and examine the impact of increasing nurse prescribing capacity in adult social care to inform future decision-making.

About this research

In March 2026, the DHSC commissioned The King's Fund to undertake a review of the evidence on the impact of nurse prescribing in adult social care. The initial results showed that there were no research studies on nurse prescribing in adult social care relevant to our search. As a result, the research questions were extended to include community-based such as primary care and community health services. There is therefore a direct relevance in similar settings across adult social care settings. Additionally, some of the professionals in primary and community health services are likely to provide care in social care settings.

This evidence review aims to support the pilot by exploring the current evidence and inform the evaluation. The review aimed to address the following questions.

4. What is the evidence base on nurse prescribing in adult social care?
5. What is the evidence for nurse prescribing within community-based care settings, including primary care and community health services?
6. In what ways can the evidence on nurse prescribing in wider community-based care be applied across adult social care settings?

02 Methods

Literature review

The search strategy was developed in line with the review questions. The strategy aimed to identify literature on nurse prescribing in adult social care, as well as its impact on services and people who use services, and nurse prescribers' professional practice. An inclusion criteria below, was created to provide a framework for the search.

Inclusion criteria:

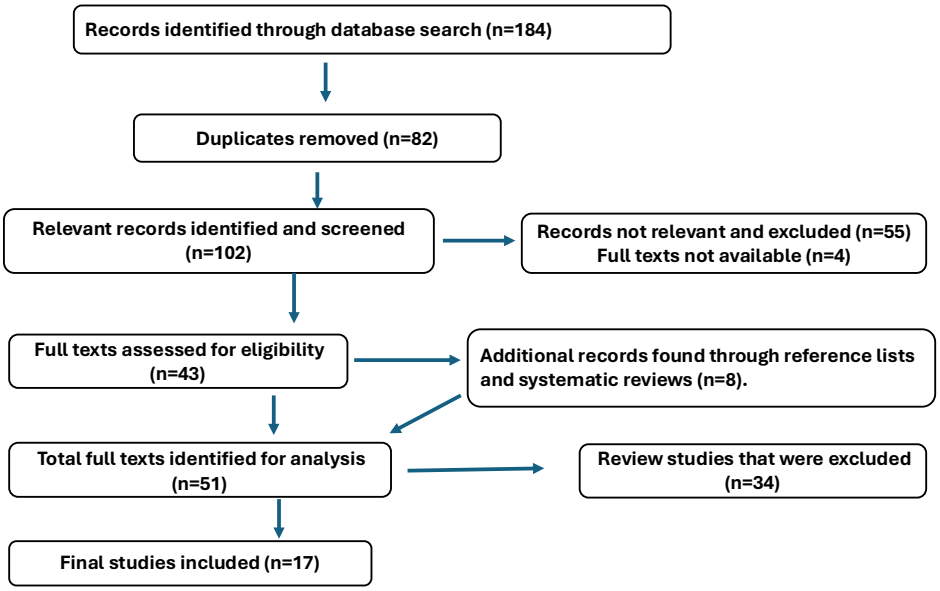
- articles published since 2006 – the time when nurses were allowed to prescribe from the full British National Formulary (BNF) within their competence.
- UK only
- English language only
- empirical studies and systematic reviews
- nurse prescribers in social care, primary and community care

The literature search was undertaken in March 2026 across five databases – Emcare, Embase, CINAHL, Medline, and The King's Fund database – alongside a supplementary web search. The review included original research studies – quantitative, qualitative and mixed-methods studies, and grey literature. See Appendix 1 for a summary of the search strategy.

The librarian at The King's Fund conducted the initial screening of titles and abstracts of potential articles. They then removed results that did not meet the above criteria and any duplicates. The search results were then sent to the researcher for screening and analysis. The researcher first screened the abstracts to identify studies relevant to the research questions. The relevant records were then categorised as either empirical studies or systematic reviews. Full texts of the empirical studies that met the inclusion criteria were then analysed and data was extracted.

Lastly, reference lists of empirical papers selected for full text review and relevant systematic reviews were also scanned to identify any additional relevant papers. Eight additional articles were identified. Where the researcher was unsure about the relevance of the study, full texts were assessed and a senior reviewer was available to advise on any uncertainties. Figure 1 details the screening process and number of studies identified at each stage.

Figure 1: Process for screening and selecting eligible studies



In total, 17 studies were selected for final review: 6 qualitative studies, 8 quantitative studies and 3 mixed-methods studies. Key data such as sample of the research, research design and findings was extracted from each individual article. The findings were then grouped into narrative themes from the findings across the different types of studies, which are discussed in the Findings section. Their characteristics were summarised and written up (see Appendix 2 for details).

Interviews with stakeholders

To test the applicability of the literature review findings to adult social care settings, we interviewed six stakeholders from five different organisations with experience in nurse prescribing within adult social care, at both national and provider levels. The interviews had two aims: first, to share the findings from the literature review and identify any gaps; and second, to gather stakeholders' critical insights on the applicability of these findings to adult social care, and their implications for policy and practice. The interviews were structured across three themes identified in the literature review to be important conditions for effective nurse prescribing: governance and safety; ongoing support and continuing professional development (CPD); and interprofessional relationships.

The interviews were recorded and summarised, and key points relevant to the research questions were identified.

Overview of stakeholder participants

We interviewed six stakeholders, five of whom had extensive experience within adult social care. Two stakeholders were responsible for workforce development (including nurse

prescribing) in social care; three stakeholders were qualified nurse prescribers and involved in the running and delivery of care within residential social care. Two of these three stakeholders were part of advisory groups in social care. One stakeholder was involved in nurse prescribing at a national level.

03 Findings

There were no studies on nurse prescribing in adult social care identified during the search. Many of the studies found were within primary care settings, with some studies (4) including community-based roles, such as district nurses, specialist community nurses, and community matrons working in people's homes. There was one national study – an economic evaluation of non-medical prescribing explicitly discussed nurse prescribing in adult social care. Of the studies that were selected, nurse prescribers in adult social care settings were integrated into the broader studies rather than being a specific focus on their own. In some instances, it was difficult to understand whom the studies' findings were attributed to. For example, some studies grouped together participants under primary care, secondary care, or bracketed them all together under the general term 'non-medical prescribers'.

Our findings are organised thematically, reflecting the main issues identified across the literature: nurses' experiences of prescribing practice; perceived impacts on care and service delivery; prescribing within competence; reasons why some nurses do not use their prescribing skills; and the role of training, support, CPD and governance. Stakeholder insights are discussed separately to consider how far these findings may apply to adult social care settings.

Experiences of job role and prescribing practice

When nurses used their skills effectively, their experiences of prescribing were mostly positive. Most of the nurse prescribers were satisfied with their role and saw the benefits of their prescribing skills to their job and the people using care services (Courtenay *et al* 2017). A major benefit reported by participants in the studies was the autonomy that nurse prescribers had in their practice, which gave them job satisfaction and increased their self-esteem (Herklots *et al* 2015; Cousins and Donnell 2012; Kelly et al 2010; Bradley and Nolan 2007; Bradley et al 2007; Courtenay et al 2007).

Although many nurse practitioners were satisfied with their role, the studies suggest that their prescribing practice varied based on their level of seniority, qualification, length of experience as a nurse and a prescriber, employer support, and care setting. These factors were associated with differences in nurse prescribers' knowledge, expertise, confidence, and use of prescribing qualifications in practice (Smith *et al* 2014; Courtenay *et al* 2012; Cousins and Donnell 2012). For example, studies by Courtenay *et al* (2012) and Cousins and Donnell (2012) found that the more the nurse prescribers prescribed, the more they became confident; they also found that nurse prescribers with more experience in their field or specialisms were more likely to use their prescribing qualifications.

Perceived impact of nurse prescribing on practice and service provision

Participants in the selected studies reported the perceived impact of nurse prescribing on their work, including their ability to be more proactive, provide holistic care and respond more quickly to service users, and, in some cases, averting potential crises (i5 Health Education North West 2015; Courtenay *et al* 2012; Latter *et al* 2010). For example, a survey by i5 Health Education North West (2015) found that having a prescribing qualification allowed the nurses to complete care episodes without waiting for review from a GP. This helped them manage their time and, in turn, improve care for people who use services. Nurse prescribers reported that the ability to prescribe medicines resulted in effective and timely holistic care, more opportunities and time to discuss medications and people's health, better care pathways, and complete care episodes (Hindi *et al* 2019; i5 Health Education North West 2015; Daughtry and Hayter 2010; Downer and Shepherd 2010; Latter *et al* 2010; Bradley and Nolan 2007). For the community nurse prescribers, delivering timely care was especially important as it helped to reduce the risk of deterioration among people who draw on care (Herklots *et al* 2015).

Other studies reported on the perceived impact of nurse prescribing on service provision (such as improved care experience) and meeting NHS targets (such as reduced referrals to GPs and hospital admissions, and improved waiting times) (i5 Health Education North West 2015; Bradley and Nolan 2007). Some nurse prescribers providing care in people's homes reported access to medicines after working hours as an additional benefit for people receiving palliative/ end-of-life care in home care (Latter *et al* 2020).

People who use care's perceptions of nurse prescribing

Only two studies in the review included people who use care in their research (Hindi *et al* 2019; Latter *et al* 2010). Latter et al's (2010) evaluation of nurse prescribing in England conducted a survey with people who use care asking about their experiences of non-medical prescribing with primary care nurses and pharmacists. They found that they had positive experiences of nurse prescribing, and valued the support they received from nurse prescribers as an alternative to GPs. Hindi et al (2019) conducted research with 24 people who use care exploring their experiences of nurse prescribing in primary care, and found similar results. In the other studies, impact on people who use, and their experiences of care was discussed from the perspective of the nurse prescribers.

Prescribing within one's competency

All the studies discussed the importance of competence, and this was often linked to nurses' confidence in prescribing and their job satisfaction (Herklots *et al* 2015; Hall *et al* 2006; Smith *et al* 2014; Courtenay *et al* 2012; Cousins and Donnell 2012). The studies found that nurse prescribers were more satisfied in their role and more confident in their prescribing when they

worked within the limits of their training, knowledge and experience (Daughtry and Hayter 2010).

However, some nurse prescribers, particularly those working in general practice, reported feeling under pressure to prescribe beyond their competence and skills. This pressure often came from colleagues, such as GPs, as well as from people who use care. A key reason for this was a lack of understanding among some health care professionals about the scope and limits of the nurse prescriber role (Herklots *et al* 2015; Cousins and Donnell 2012; Daughtry and Hayter 2010; Downer and Shepherd 2010).

Why some nurse prescribers do not use their prescribing skills

Some studies found that there were nurse prescribers who were qualified but did not use their qualification (Latter *et al* 2020; Hall *et al* 2006; Courtenay *et al* 2017; Herklots *et al* 2015; Bradley and Nolan 2007). The reasons given for this included inadequate governance and support structures (eg, from line managers and other colleagues) (Courtenay *et al* 2017; Bradley *et al* 2007); lack of confidence due to limited (or absence of) CPD (Courtenay *et al* 2007); trust issues between the prescribers and other clinical colleagues (Hindi *et al* 2019); and limited access to GP records (Latter *et al* 2020).

Training, supervision and ongoing support

Training, supervision and support was discussed in many of the studies. Nurse prescribers' job satisfaction was intertwined with training that met their needs, adequate supervision, and continuous support (Herklots *et al* 2015; Smith *et al* 2014; Latter *et al* 2007). Latter *et al* (2007) found that nurse prescribers appreciated supervision and support from medical colleagues who were 'encouraging and non-threatening'. Having adequate training and supervision ensured that the nurse prescribers had the knowledge and expertise needed in their specialist areas.

After training and qualifying, ongoing support was considered essential to their professional development and increased their likelihood of nurse prescribers using their prescribing skills. It also helped to facilitate their NMC revalidation and to maintain clinical competence. All participants in the studies reported that the support they expected in relation to their prescribing role included opportunities to attend professional development courses, as well as funding and backfill.

For those who were satisfied with the support they received, examples of sources of support included GPs, medical colleagues, mentors, other nurses and nurse prescribers (Herklots *et al* 2015; Latter *et al* 2010; Latter *et al* 2007). GP services were better able to provide support and supervision for nurse prescribers because they were reported to have established systems and infrastructure in place. For example, some GP services had non-medical prescribing (NMP) leads responsible for all prescribers, quality assurance and risk management (Smith *et al* 2014; Courtenay *et al* 2012; Latter *et al* 2010). They helped prescribers with their professional

development training needs, shared information about available training opportunities and delivered training for their NHS trust (Courtenay *et al* 2011; Courtenay *et al* 2012).

However, experiences of support were reported to be mixed across settings. There were differences in the availability of support between nurse prescribers working in general practice and those in community-based roles (Smith *et al* 2014; Courtenay *et al* 2012; Cousins and Donnell 2012; Downer and Shepherd 2010; Kelly et al 2010; Latter et al 2007). For example, Herklots et al (2015) found that community matrons generally valued the informal support they received from GPs and colleagues but reported a lack of formal support structures. Similarly, Smith et al (2014) found that community-based nurse prescribers were less likely to receive adequate support. This lack of support was partly attributed to the lack of understanding of the nurse prescriber role, its benefits to services and care for people who use care, and the nature of the role spanning multiple settings.

Interprofessional relationships and team working (such as with GPs and other medical and prescribing colleagues) were found to be important to the community-based care nurse prescribers (Hindi *et al* 2019; Daughtry and Hayter 2010; Bradley *et al* 2007). These relationships are important as they become sources of support, of CPD, and can build nurse prescribers' confidence as they share knowledge, and can ask questions.

Continuing professional development

CPD is mandatory for all nurses, to help maintain safety and practice. It can be formal and informal (NMC revalidation). As with issues around support for nurse prescribing, access and experience of CPD courses varied among different prescribers (Smith *et al* 2014; Bradley and Nolan 2007). Two surveys, Latter *et al* (2020) and Smith *et al* (2014), found that community nurses often struggled to access CPD because training opportunities were limited within their services. This meant that the training they did receive was inadequate to support safety for people who use care.

For those who had access to CPD courses, the studies showed different ways that the prescribers accessed training and the types of training available to them (i5 Health Education North West 2015; Smith *et al* 2014; Courtenay *et al* 2007; Latter *et al* 2007). For example, Smith *et al* (2014) found that all the participants used several strategies to keep up to date on their prescribing, such as using the internet for self-directed study, and in-house training courses, some of which had funding provided.

Governance and safety

Safety and governance are intertwined with the themes already discussed (job satisfaction, confidence, training and support, and CPD). The studies showed that organisations had different governance structures to support prescribers. Participants reported that having formal governance structures was crucial to their professional development (Courtenay *et al* 2017). Participants working in the NHS were more likely to report positively on having governance

structures that supported their professional development. This was because they had non-medical prescribing committees, NMP leads, and policies and systems for safety, quality assurance and risk management (Smith *et al* 2014; Latter *et al* 2010). However, some studies found that some organisations did not record or audit prescribing data crucial to evidencing safety and CPD needs, and there were fewer formal governance structures in place for community nurse prescribers (Courtenay *et al* 2012). Smith *et al*'s (2014) study found that governance structures did not sufficiently monitor experiences of patients and people who use care as part of their quality assurance.

Summary of challenges to nurse prescribing practice

All of the studies cite various challenges to effective prescribing practice. Below are the barriers that nurse prescribers themselves reported.

- *Increased workload and responsibility*. This was a concern for some prescribers, especially those in primary care. They reported issues with having to manage patients and people who use care's with more complex health needs, with little time for consultations but increased responsibility and pressure to prescribe (Cousins and Donnell 2012; Daughtry and Hayter 2010; Kelly *et al* 2010).
- *Challenging relationships.* Some reported experiencing challenging relationships with colleagues who were unclear about the nurse prescribers' prescribing competence and authority (Daughtry and Hayter 2010; Kelly *et al* 2010; Latter *et al* 2010).
- *Limited access to GP records*. The studies showed variability in nurse prescribers' access to GP records. Community nurse prescribers (eg, working in home care) faced specific issues such as limited (or lack of) access to GP records, describing these as barriers to prescribing certain medications and to updating the records. As a result, they reported often having to refer to a GP when they were not confident about prescribing certain medications without access to the records (Latter *et al* 2020; Herklots *et al* 2015; Hall *et al* 2006; Smith *et al* 2014).
- *Dissatisfaction with the lack of increase in salary or higher grade after qualifying as a prescriber* (Cousins and Donnell 2012; Kelly *et al* 2010). In adult social care, there is no standardisation in salaries in comparison to the NHS. Salaries for nurse prescribers are largely determined by employers, based on an individual's experience, clinical competence, and local market conditions (Skills for Care 2025; Atkinson *et al* 2024).
- *Working in silos.* Nurse prescribers working in primary care often work closely with other teams and may have primary care network (PCN)-level support. However, community nurse prescribers were more likely to report working in silos.

04 Insights from stakeholders

Evidence on nurse prescribing in adult social care

Although the findings discussed above are mainly from health care, during interviews with stakeholders they agreed that the themes presented to them were crucial to effective nurse prescribing in adult social care. However, they noted that the challenges experienced by nurse prescribers in adult social care in relation to the three themes (governance and safety, ongoing support and CPD, and interprofessional relationships) were different.

All six stakeholders interviewed confirmed the dearth of research and evidence specifically on nurse prescribing in adult social care. They were concerned that without baseline evidence, the implementation of the pilots would be weakened, limiting what can be learnt from them for the next steps.

They had different views on the reasons for this lack of research. One stakeholder suggested that it may reflect limited awareness and understanding of nurse prescribing within adult social care and the wider health and care system, which is why it was not a priority.

Benefits of nurse prescribing in adult social care

The stakeholders were clear about the value that nurse prescribing can bring to adult social care settings. They highlighted three related benefits. First, nurse prescribers can provide more timely care without always having to wait for GP input. Second, timely prescribing can help residents remain in the care home where appropriate, reducing avoidable hospital admissions and helping to achieve wider NHS targets. Third, nurse prescribers working in care homes often know residents well, see them regularly, and understand changes in their health needs. This knowledge can help them identify deterioration earlier and respond more quickly.

Support and continuing professional development

All the stakeholders concurred on the importance of support and CPD opportunities for nurse prescribers to be able to prescribe within their competence and for people who use care's safety. One stakeholder noted that support and CPD should be considered from the time nurse prescribers qualify and thereafter. Additionally, all six stakeholders highlighted that support structures and CPD needed to be considered as part of governance structures. This is to ensure that the support and funding for CPD is planned for in advance.

The literature review found that district nurses and other community based nurse prescribers reported being disconnected from wider teams, which left them feeling unsupported and limited their access to CPD opportunities. In contrast to these findings, the stakeholders had mixed

views on whether this applied to adult social care nurses. One stakeholder described nurse prescribers as connected to different teams and multidisciplinary groups, and having access to CPD opportunities in their organisation. Others noted that siloed working could still be a risk in care homes. They reflected that siloed working and limited access to CPD could be especially challenging for nurse prescribers working for small independent providers with limited budgets for training and CPD.

The stakeholders also raised other challenges that could affect nurse prescribers' professional development. Five stakeholders reported that nurse prescribing education and CPD can be resource intensive for some providers and nurse prescribers. This includes the costs of training and the need for backfill so that staff can attend training programmes.

Governance and the right infrastructure

All six stakeholders agreed that robust governance structures – an organisation's quality assurance and risk management processes – were essential to effective nurse prescribing and safety for people who use care. One stakeholder further added that it was important for providers to note that safety was not only an individual nurse prescriber's responsibility but the responsibility of the provider organisation as well.

The stakeholders noted that governance structures differ between adult social care providers as they vary in size and level of resources available to them – from larger chains to small independent providers. This then has an impact on how the nurse prescribers work – for example, some nurse prescribers work within a care home, whereas others may work across care homes and in people's homes.

The stakeholders advised that policy-makers should also not assume that governance structures for prescribing exist or are adequate. They raised questions about which models of nurse prescribing would make best use of nurses' skills, expertise and relationships with people who draw on care. In their view, policy-makers need to consider the diversity of care home settings, including differences in provider size, resources and existing infrastructure. They also highlighted the need to identify models of nurse prescribing (including prescribing and deprescribing) that are feasible for different providers and offer value for their investment. Deprescribing is where a nurse prescriber reduces or stops an individual's medications.

Stakeholders further noted that these models would depend on the strength of governance arrangements, wider infrastructure, and working relationships with health professionals.

Stakeholders also highlighted the significant challenges experienced by nurse prescribers in care homes, such as GPs having inconsistent approaches to nurse prescribers accessing GP records. For some stakeholders, lack of access was linked to the lack of trust between organisations working in health and social care. Other stakeholders gave examples of having different agreements with GPs on how nurse prescribers could input data onto an individual's records and see what medications they were on. These variations can affect nurse prescribers'

confidence and engagement, and shape what they feel able to prescribe or deprescribe, particularly in more complex cases.

Stakeholders further discussed additional issues that they reported were important to the infrastructure necessary for effective nurse prescribing in social care. First, they noted the inconsistent mechanisms in funding for prescription pads (forms used to write out prescriptions) between health and social care, with uncertainty over the willingness or ability of adult social care providers to cover those costs.

Second, stakeholders were concerned about the risk of nurse prescribers not using their qualifications over time due to some of the aforementioned challenges. When qualified nurses do not use their prescribing skills, it is costly to the provider (return on investment), and staff may experience frustration and demotivation.

Third, the stakeholders were concerned about duplication of roles between nurse prescribers in care homes and other NHS advanced nurse practitioners (ANPs) and advanced clinical practitioners (ACPs) already operating in these settings. The NHS staff worked in care homes through different arrangements – either as part of teams commissioned by ICBs or employed by GP practices to work across multiple care homes.

To address these issues, all the stakeholders suggested that first, policy-makers needed to recognise that nurse prescribing is more than just equipping individuals to work in care homes. They also emphasised that a system-wide approach to developing effective nurse prescribing infrastructure is essential. Their suggestions for a system-wide approach contrasted with the findings from the reviewed studies, which were more focused on governance and safety for people who use care at the organisational level.

The six stakeholders interviewed identified several advantages of taking a system-wide approach.

- It could help address fragmentation between health and social care, including duplication of roles and uncertainty about how teams across the system should work together.
- Better integration between health and social care could help clarify how nurse prescribing is governed, including responsibilities for clinical oversight, supervision and accountability. This may be particularly important for small independent providers with limited capacity.
- The governance structures can also help provide greater consistency in nurse prescribers' access to and ability to update the records of people who use care.
- It would help ICB leaders consider nurse prescribing training, support and CPD in adult social care as part of the wider health and social care workforce – and not in isolation. Working in this way can also help create the conditions for stronger collaboration and governance relationships between primary care and social care.

National bodies such as the DHSC can support a system-wide approach to nurse prescribing in adult social care by creating national guidance to help ICBs develop system-wide expectations around governance, information-sharing, prescribing infrastructure and workforce planning.

More importantly, the stakeholders noted that policy-makers need to be clear about the

intended function and outcomes of nurse prescribing in adult social care. This would help identify the types of models that would work, for whom, and under what conditions, drawing on evidence.

Interprofessional relationships

All six stakeholders agreed that interprofessional relationships across health and social care were important. They reported their frustrations with some health professionals not understanding the role and competences of nurse prescribers, and not ‘crediting them for their professionalism’, which affected relationships with them. Stakeholders noted that a system-wide approach to governance for nurse prescribing could improve collaboration and strengthen relationships between health and social care professionals, which would be beneficial to all.

05 Discussion

The review shows that there is a dearth of literature on nurse prescribing in adult social care, and the stakeholders interviewed confirmed the findings. Stakeholders had different views on the reasons for this gap in research, including negative views held by some health care professionals about nurse prescribing in adult social care. However, the literature also shows that generally, the reasons for this lack of the research are often inferred from adult social care history and trajectory over time, such as the fragmentation of the sector, commissioning differences, scope of roles, and reduced funding for research in comparison to health care (Sumpter *et al* 2025).

Although NIHR funding into social care and the nurse prescribing pilot are welcome, there was consensus among the stakeholders that policy-makers such as the DHSC should consider more consistent funding for nurse prescribing in adult social care with specific research priorities. More research is needed to build the evidence base to improve understanding of the experiences of nurse prescribers and the people who use care, as well as the barriers to and most effective approaches and models for nurse prescribing. The research should also include providers, nurse prescribers, and the people who draw on care in order to get a better understanding of their experiences.

The literature review and interviews with stakeholders show that certain conditions (both within an organisation and across the system) are essential for nurse prescribers to use their qualifications and prescribe effectively. These conditions include robust governance structures to support safety and quality of care for people who use care, as well as adequate resources for CPD, which vary across providers.

Stakeholders were clear about the value of a system-wide approach to thinking about models of nurse prescribing that work for the diversity of providers. Stakeholders also noted that this diversity means there is unlikely to be a single model of working between care homes and GP practices that will work for all providers. For example, smaller providers may experience particular challenges in relation to additional resource requirements. A system-wide approach is also useful for addressing the multiple interconnected barriers to effective nurse prescribing in social care.

We acknowledge that the need for better collaboration between health and social care is not new; multiple reports, policy papers and frameworks have been developed to support this view. But in practice, there are variations in how adult social care providers work with GPs and other primary care professionals at a local level. These differences are shaped by local care models, commissioning and funding practices, and the capacity of both social care and primary care providers.

ICBs have a key role to play in developing a system-wide approach to effective models of nurse prescribing and infrastructure in adult social care, and bringing together partners across the system. Integrated workforce planning and adequate resourcing across health and social care will be essential enablers for this work.

The current social care nurse prescribing pilot also provides an opportunity for ICBs to explore challenges to nurse prescribing in social care (some of which were discussed by the stakeholders interviewed for this research), and how they can mitigate them, working with all partners across the system.

06 Limitations of the literature review

One limitation of the review is that some of the studies were conducted early in 2006 and 2007 just after the introduction of the policy that allowed nurses to prescribe from the full BNF – a time when the idea of nurse prescribing was still very new. Other studies were conducted at a time when there were other national policy changes to nurse prescribing, some of which have seen nurse prescribing integrated in primary care. However, various barriers identified in the literature remain relevant today. For example, stakeholders confirmed that access to GP records, and information-sharing between primary care and adult social care, continue to be significant challenges for effective nurse prescribing in care homes.

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Appendix 1: Summary of the search strategy

Concept	Purpose / scope	Example keywords and phrases
1. Nurse prescribing	Identify nurse prescribers and nurse-related prescribing activity	nurse prescrib*; nurse independent prescrib*; nurse supplementary prescrib*; non-medical prescrib* adj3 nurs*; community practitioner nurse prescriber*;; independent prescriber; supplementary prescriber
2. Community-based care settings	Capture primary care, community health services, and adult social care contexts	primary care; general practice; community health service*; community nurs*; district nurs*; adult social care; social care; domiciliary/home care; care home*; residential care; nursing home*; day service*; supported living; respite care, neighbourhood health care
3. Conditions for implementation and influences on prescribing practice	Identify organisational and professional factors shaping implementation and prescribing behaviour	implementation; barrier*; facilitator*; organisational support; managerial support; training; education; competence; capability; scope of practice; role clarity; prescribing practice*; guideline adherence; decision-making; interprofessional working
4. Patient experiences, health outcomes and quality of life	Capture service-user impacts of nurse prescribing	patient experience*; patient satisfaction; patient outcome*; health outcome*; quality of life/QoL; access to care; continuity of care; patient safety; medication error*; adverse event*
5. Barriers and facilitators in community care settings	Identify factors helping or hindering nurse prescribing specifically in community/ASC settings	barrier*; facilitator*; implement* adj3 nurs*/prescrib*; workload; time constraints; organisational culture; resource availability; staffing; acceptability; feasibility; professional boundaries; regulatory/governance constraints

Appendix 2: Overview of included papers

Author	Settings and participants	Study type	Focus of the research
Courtenay *et al* (2012)	A strategic health authority in England. Total participants (n=883). Prescribers not prescribing (n=133).	Quantitative study using surveys.	The aim of the study was to provide an overview of non-medical prescribing across one strategic health authority.
Courtenay *et al* (2007)	National survey – primary care and community care in the UK. Total participants (n=868).	Quantitative study using surveys.	The aims of the study were to provide an overview of the prescribing practices of nurse prescribers and the factors that facilitate or inhibit prescribing
Kelly *et al* (2010)	Primary care in England. Nurses (n=151). Nurse prescribers (n=40).	Quantitative study using surveys.	The study aimed to understand the experiences of nurse prescribers and barriers to training and prescribing practice.
Latter *et al* (2010)	National evaluation in the UK. Nurses (n=976). 86% nurse prescribers (n=208). Patients (n=141).	Multi–method design. Surveys, workshops, case studies focus group.	The aim was to evaluate nurse and pharmacists' independent prescribing in England.

Smith *et al* (2014)	1 strategic health authority, part of the bigger study in 2010 in England. Total responses (n=976).	Quantitative study using a survey.	The aim was to explore the adequacy of educational preparation for nurse prescribing and identify CPD and clinical governance strategies in place
Latter *et al* (2020)	Community palliative care in England, community pharmacy. Total responses (N=1327). Community-based end-of-life care. GP practices. Patients' homes.	Quantitative study.	The study explored patient access to medicines in community palliative care and health professionals' practice, perceived effectiveness and influencing factors. Most nurses and GPs were providing home care. Barriers to prescribing education and using their qualification. Use of prescription pads.
Hall *et al* (2006)	Primary Care Trusts in England. Total community nurse prescribers (23). Total prescribing leads (34)	Mixed-methods study: quantitative and qualitative.	Aims of the research were to identify barriers that could either prevent community nurses from prescribing altogether or reduce the number of times that a nurse might prescribe.
Herklots *et al* (2015)	2 primary care trusts in England. Community matrons (n=7).	Qualitative study using interviews.	The study was exploring community matrons' experiences.
Cousins and Donnell (2012)	Primary care – group of practices in Liverpool, England. Total participants (n=6).	Qualitative study using interviews.	The aims of the study were to explore the nurse prescribers' experiences.

Latter *et al* (2007)	Primary and acute care in England. Total participants (n=246).	National study. Quantitative study.	The study evaluated nurse prescribers' education and CPD for independent prescribing practice in England.
Hindi *et al* (2019)	Primary care in England. The study was funded by Health Education North West. Total nurse prescribers (n=14). Patients (n=24).	Mixed methods. Quantitative and qualitative.	The aims of the research were to explore the perceptions and experiences of patients, prescribers and their colleagues around prescribing.
Daughtry and Hayter (2010)	GP practices in England. Nurse prescribers (n=8).	Qualitative study using interviews.	The study explored practice nurses' prescribing experiences. Barriers to prescribing.
Bradley and Nolan (2007)	GP practices in the UK. Total participants (n=45). Nurses with no qualification (n=10).	Qualitative study using interviews.	The aims of the study were to explore nurse prescribers' experiences.
Bradley *et al* (2007)	Primary, acute care, West Midlands (England). Total participants (n=31).	Qualitative study using interviews.	The study explored how recently qualified nurse prescribers describe, and rate, the safety of their prescribing.

i5 Health Education North West (2015)	Primary and secondary settings in the north-west of England. Total non-medical prescribers from 42 organisations (n=1566).	Mixed-methods study.	The aims of the study were to evaluate the economic impacts of non-medical prescribing, including benefits to patient outcomes and economic benefits to the health and care system.
Downer and Shepherd (2010)	Community-based care in Glasglow. District nurses qualified as prescribers (n=8).	Qualitative studies using interviews.	The aims of the research were to explore the lived experiences of district nursing in Scotland.
Courtenay *et al* (2017)	National survey in 3 NHS trusts and seven health boards in Wales. Total non-medical prescribers (n=606).	Quantitative study using survey.	The aims of the research were to describe the non-medical prescribing workforce, examine how prescribing is implemented and used in practice, and their safety and governance systems.

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