

Why you should read this article:

- To refresh your knowledge of non-medical prescribing (NMP) roles and responsibilities
- To learn about a study that was undertaken to gather insights on the implementation of NMP in social care organisations
- To recognise the importance of new models of integrated working to support the effective implementation of NMP in social care

Understanding and advancing nurse prescribing in social care

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Citation

Pryor C, Kelly S, Stephens M (2026) Understanding and advancing nurse prescribing in social care. *Nursing Management*. doi:10.7748/nm.2026.e2217

Peer review

This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest

None declared

Accepted

18 June 2026

Published online

September 2026

Abstract

Background Non-medical prescribing (NMP) is a relatively new and underutilised addition in social care nursing settings.

Aim To gather insights from prescribers and stakeholders regarding the implementation of NMP in social care organisations.

Method Semi-structured interviews were conducted with five prescribers and a stakeholder with experience of NMP in social care settings across England. Data were generated and analysed using reflexive thematic analysis.

Analysis Four themes were constructed; working in collaboration; demonstrating the impact of NMP; constructing professional identity; and preparing the path forward.

Conclusion Prescribing in social care is poised for rapid expansion. However, new models of working and robust leadership are essential to foster interorganisational connectivity, provide appropriate support, and establish the infrastructure required for effective service delivery.

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Keywords

advanced practice, clinical, medicines, nurse prescribing, practice development, prescribing, prescription medicines, professional, professional issues

Background

Nurse prescribing has become an integral component of modern healthcare, enabling timely, person-centred interventions and supporting advanced nursing practice. However, while nurse prescribing is well-established in the NHS, its use in social care remains limited. In the UK, adult social care refers to care provided to individuals outside of the NHS and focuses on supporting people who have mental or physical care needs to maintain their independence or quality of life (Longo et al 2023), or providing care for people with other complex support

needs such as learning disabilities. Social care may be delivered in a person's own home, care home or wider services such as non-NHS funded intermediate care, charity settings, hospices, resource services or day centres (Kelly et al 2025, Pryor et al 2026). These services may have registered nurses directly working within them or overseeing service provision.

Recent policy initiatives – including the move toward neighbourhood models of health and social care (Department of Health and Social Care (DHSC) et al 2025, NHS England 2025) and the Adult Social Care Nurse Prescribing

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Pilot (DHSC 2025a) – have signalled a renewed focus on expanding prescribing roles beyond the NHS. This article explores the implementation of non-medical prescribing (NMP) in social care, examining the associated opportunities and challenges, as well as the organisational structures required to support safe, effective practice.

Nurses and non-medical prescribing

The prescribing of medicines and medical devices by healthcare professionals who are not doctors or dentists is well established within the UK (Cope et al 2016). For nurses and allied health professionals, gaining legal prescribing rights requires additional post-registration practice development, completion of an approved prescribing programme of study, and entry onto a subsection of the register of the relevant professional body to validate their legal ability to prescribe. For nurses, this results in a prescribing annotation on the Nursing and Midwifery Council (NMC) register.

Within the UK, nursing is the largest NMP profession, with nurses managing full episodes of care from initial and subsequent assessment, diagnosis, formulation of care plans, consideration of relevant medicines, prescribing decision-making, and reviews at an increasingly advanced level (Armstrong et al 2021).

Individual prescribers are recognised by an annotation on their professional register which indicates the type of NMP they are legally allowed to practice (Pryor et al 2023). This may include independent prescribing (IP), where an independent prescriber takes responsibility for a full episode of care. Alternatively, it may relate to supplementary prescribing (SP), where the supplementary prescriber makes prescribing decisions in line with a legal clinical management plan (CMP) co-created with a named medical prescriber (the independent prescriber in this legal context, who must be a doctor or dentist), and the specific individual the CMP is in place for. In this partnership, the named independent prescriber (doctor or dentist) retains overall responsibility, and with agreement of the specific individual being prescribed for, the supplementary prescriber can make prescribing decisions provided they are within the parameters of the CMP.

A further NMP role is community practitioner nurse prescribing (CPNP), which enables nurses to prescribe from a limited nurse prescribers formulary (Dunn and Pryor 2023).

While other healthcare professionals – for example podiatrists, dietitians and paramedics – share the same legal prescribing annotations and titles (independent prescriber, supplementary prescriber), it is paramount for nurses, service managers, and service providers to understand the legal variations in the permitted prescribing methods and controlled drug restrictions (types, forms and routes) for various other non-medical healthcare practitioners (Health and Care Professions Council (HCPC) 2026). Table 1 details the professional prescribing variations across the NMC, HCPC and General Pharmaceutical Council (GPhC) registers.

Local adaptations of prescriber naming conventions seen across organisations and departments, and personal naming preferences are inconsistent and confusing. The terms non-medical prescriber and NMP are charged and draw attention for identifying highly skilled and educated professionals as something ‘non’. Appreciating this, while also considering the complex number of prescribing professionals and the different models of prescribing available across professions, the authors recognise the term NMP as a useful collective noun; effective in describing groups of prescribers in policy and governance documents.

This article relates to nurse independent and supplementary prescribers and it supports the individual naming approach discussed by Pryor et al (2023), whereby the professional registration is identified alongside the unabridged legal prescribing rights afforded to the individual. While the focus of the article is on nurse independent and supplementary prescribers, this research recognises and draws on the experience of other non-medical prescribers working outside the NHS.

Nurse prescribing

Nurse prescribers are a sought-after group in line with the increase of specialist and advanced nursing roles, reflecting the increasing incidence of multimorbidity, complexity and demand on healthcare systems. This has driven an expansion of nursing scope of practice (Fox et al 2022) to include management of both long-term conditions in people requiring higher levels of service and contact with professionals to meet their prescribing needs (Armstrong et al 2021).

Nurse prescribing has been shown to be as safe as medical prescribing (Funnell et al 2014), and informs holistic care; however, it is recognised that nurses may feel undue pressure to prescribe to the detriment of other facets of

Implications for practice

- Supporting governance and process is paramount to supporting workforce talent and ability
- Establish robust co-created collaborative governance frameworks which are accessible across all aligned service providers, and which include the Royal Pharmaceutical Society competence framework
- Design clear processes for student and qualified prescribers permitting access to shared digital resources and electronic patient records
- Ensure clarity and understanding of budgetary pathways including prescribing cost codes and NHS Business Service Authority processes
- Align setting insurance and job descriptions to permit prescribing and embed continuing professional development and expanding scope of practice provision

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the nursing role and workload (Lennon and Fallon 2018). All prescribing practice centres on a prescriber's defined scope of practice, individual competence, confidence, and terms and conditions of employment relating to the specific job role they are undertaking.

Nurse prescribing is established in the NHS and in NHS sub-contracted services, with nurses having access to associated governance, shared information systems and budgets. However, social care settings often experience additional complexity associated with the necessary mechanisms for prescription generation such as insurance and prescription generation mechanisms such as electronic prescribing systems, and centralised prescribing formularies and guides (Neil et al 2021). As a result, nurse prescribing in social care has remained limited.

Aim
To gather insights from prescribers and stakeholders regarding the implementation of NMP in social care organisations.

Method
This study was conducted in England to understand challenges and facilitators to implementing prescribing and advanced

nursing practice in social care settings. A 'Big Q' qualitative approach was adopted by the authors, using reflexive thematic analysis to interpret participants' experiences, thoughts and considerations. The Big Q qualitative approach recognises meaning as being socially and contextually produced, enabling a rich exploration of participants' accounts. It emphasises researcher reflexivity and the active role of the researcher in interpreting and creating meaning from qualitative data. Meaning and themes are constructed (not 'found') by the researcher, to offer insight and understanding (Braun and Clarke 2024).

Study phases
The study comprised two phases:

- » Phase one – the pre-research phase. A 'world café' style engagement event was held for non-medical prescribers, stakeholders, academics, educators, service providers (both NHS and social care sector) and policymakers. This event was held at the University of Salford, England, and focused on exploring prescribing in social care and associated settings through presentations of practice and facilitated discussions.
- » Phase two – the research phase. Attendees of the word café event and other associated stakeholders who were not present at the world café, were invited to take part in interviews to explore their experiences, reflections and perceptions of prescribing in social care. The interview questions used a topic guide based on the messages from the world café and focused on prescribing governance, partnerships, education and supervision, and scope of practice. The interviews were conducted online by the lead researcher (CP), recorded and transcribed using Microsoft Teams, then checked for accuracy. The interviews took place between April and June 2025.

Participants
Convenience sampling was used to recruit participants from attendees at the world café event. Study information packs were available on tables and could be taken away by attendees for later review. Follow-up emails were sent to attendees, and the lead researcher contacted other individuals with relevant knowledge or experience who had not attended the event.

Six participants agreed to take part. Participants included four nurse independent and supplementary prescribers, one pharmacist independent and supplementary prescriber,

Table 1. Professional prescribing variations across the Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC) and General Pharmaceutical Council (GPhC) registers			
Profession	Regulator	Title and annotation	Detail
Nurse	NMC	Community practitioner nurse prescribing (CPNP)	Studied within a community nursing specialist practice qualification, specialist community public health nurse qualification, or standalone qualification
Nurse	NMC	Independent prescriber (IP); supplementary prescriber (SP)	Combined annotation. Can no longer be taken in isolation. Nurses must now undertake a dual IP/SP qualification
Chiropodist/ podiatrist	HCPC	IP/SP	IP Controlled drug restrictions in place
Paramedics	HCPC	IP/SP	IP Controlled drug restrictions in place
Physiotherapists	HCPC	IP/SP	IP Controlled drug restrictions in place
Therapeutic radiographers	HCPC	IP/SP	IP Controlled drug restrictions in place
Diagnostic radiographers	HCPC	SP	Can only register and practice as an SP
Dietitians	HCPC	SP	Can only register and practice as an SP
Pharmacist	GPhC	IP and/or SP	Pharmacists can be either an IP or SP, or both

and one manager from a service interested in introducing prescribing to their service. All were from social care services (including care homes and hospice care). Four participants were individually interviewed, with the two remaining participants preferring to be interviewed jointly.

Data analysis

The authors used the six-step reflexive thematic analysis process to analyse the data (Figure 1) (Braun and Clarke 2024).

Reflexive thematic analysis facilitated inductive and latent theme development, which enabled specific, contextual, political and practice-based analysis of participants' experience and accounts. The authors engaged in flexible, iterative coding, drawing on their professional, nursing and sociological expertise as well as the lead researcher's background in NMP. Coding was undertaken independently and then collated through discussion.

Ethical considerations

Ethical approval was granted by the University of Salford (reference number 5032). Participants had the opportunity to discuss the study with the research team to ensure informed consent. They signed consent forms before any research activities began. All recordings were anonymised and unique identifier numbers were allocated to each participant.

Analysis

In keeping with the reflexive thematic analysis reporting guidelines (Braun and Clarke 2024), this section presents what has previously been known as 'findings', moving away from the notion that themes are 'found,' or passively 'emerge,' and embracing the creation of understanding and shared meaning from the analytical process.

Four themes were constructed: working in collaboration; demonstrating the impact of NMP; constructing professional identity; and preparing the path forward.

Working in collaboration

The study found that governance, infrastructure, supervision, digital systems and interprofessional relationships all influenced non-medical prescribers' practice. Participants described having to navigate connections and disconnections across organisational boundaries across these domains. Despite delivering care based on health needs, participants often lacked the infrastructure, support and policy mechanisms afforded to NHS colleagues, which created uncertainty and inconsistency in practice.

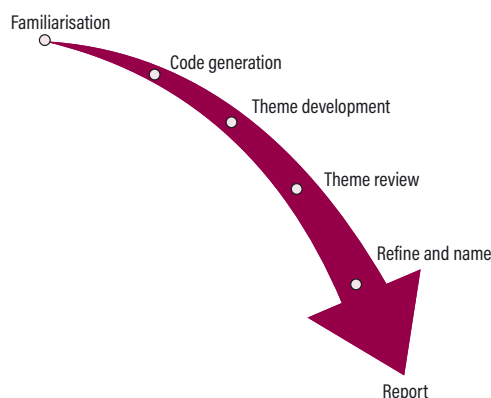
Participants also discussed the difficulty of achieving consistent governance and operational clarity when multiple organisations were involved. Engagement with commissioning and system leadership was fragmented and dependent on local understanding of prescribing roles. One of the participants recounted the complexity involved in setting up a prescribing service in an independent hospice:

'The ICB [integrated care boards] or the commissioning service at the time kept pushing me from pillar to post because again, it was really evident there were people in very senior positions who were not prescribers, who didn't really understand the value of it, and certainly didn't even know where to begin. I think what really helped within the ICB is when we got that pharmacy leadership.' (Nurse prescriber 3)

Where some participants suggested that governance and quality assurance might best be situated within existing system structures (such as established ICB processes), others emphasised the need to strengthen relationships and frameworks that spanned health and social care and indicated that cross-organisational contracting arrangements would provide support for areas where residents access multiple GP practices. The establishment of organisational agreements and honorary contracts between social care and NHS services was presented as a practical mechanism to integrate prescribing across health and social care, as one participant commented:

'Number 1, remove barriers at the highest level... then strengthen the ICB relationship with social care. Make sure that they have a clear pathway with a framework approach... This transferability of skills across areas is going to be complicated because we all work

Figure 1. Six steps of the reflexive thematic analysis



in different GP practices. So, it will be different honorary contracts or something like that.'

(Nurse prescriber 2)

Possible solutions to the disconnection of services were identified through system-wide approaches, as one participant suggested:

'If you're a lone practitioner in a care or nursing home... this is where the ICB has that opportunity to provide a supervision network within the integrated care system.'

(Nurse prescriber 3)

A lack of digital access and interoperability were also barriers to service delivery. Some participants described how GP practice systems limited documentation and continuity of care, and that improved digital integration could act as an enabler of safer, more efficient and accountable care:

'I had a resident who needed to be seen, and I could go and assess him, but I couldn't write up my consultation because he wasn't with that practice, so they had to come out and see him.'

(Nurse prescriber 1)

'It's the digitalisation of that process that would make it happen, and either through some honorary contract or some kind of contract.'

(Nurse prescriber 4)

Participants also identified access to supervision for non-medical prescribers as an important factor affecting the development of NMP in social care, with one participant stating:

'I absolutely agree that there is a big gap when there isn't a mentor and if the local GP or frailty nurse or ANP [advanced nurse practitioner] does not want to take that on, that nurse is stuck. They can't go anywhere without that in place.'

(Nurse prescriber 4)

With regards integration of services, some participants drew comparisons with GP practices, many of which are private businesses that deliver NHS services and questioned why non-medical prescribers in social care could not operate within a similar framework:

'GPs are private business. They just claim for the NHS service that they provide. And I do think that the logical thing would be to tap in into the same model where we are within private health and social care... in the care homes, residents [may] get their FNC [NHS-funded nursing care] – that could be seen as part funding if there is a nurse prescriber... they are employed by the private business the same way as the GP practice is a private business employing practice nurses and ANPs.'

(Nurse prescriber 4)

Here, the participant recognised the complexity of funding pathways, noting that GP services are private businesses and claim

funding back or are contracted to deliver NHS services. It seemed confusing to the participant why other private businesses cannot operate in the same manner if they are delivering a service that would be typically delivered by GP or wider NHS services. It raises the important point that some residents in nursing care settings are entitled to and in receipt of NHS-funded nursing care, so why this is not used to support prescribing in social care organisations?

Participants also emphasised the importance of consistency in implementation, governance and evaluation of prescribing practice to sustain quality outcomes, with one stating:

'Let's be consistent with how this is implemented and funded, but then actually let's be consistent over how we support it, monitor it and deliver it.'

(Pharmacist prescriber)

These discussions illustrate that non-medical prescribers operate within a complex and fragmented health and care system, where their integration is influenced by governance structures, interorganisational relationships and system-level support. While participants acknowledged the potential of ICBs to coordinate supervision, provide oversight and link services, gaps in infrastructure and digital connectivity continue to create barriers. Consistent standards, clear frameworks, and system-wide approaches across NHS and social care services were seen as essential to ensure that non-medical prescribers can function effectively and safely and support improved care delivery.

Demonstrating the impact of non-medical prescribing

Participants articulated how NMP not only improves access and continuity of care for patients but also reduces pressures elsewhere in the system, describing both a clinical and organisational impact. Prescribing autonomy was understood to enable responsive and person-centred care, particularly in situations where timely access to medicines was difficult. For example, one participant described how non-medical prescribers can act swiftly and use their specialist scope of practice to provide continuity for residents, avoiding delays and unnecessary referrals to GPs:

'There are real challenges sometimes in pharmacies getting the medication so they [the pharmacy] may be able to get morphine but not diamorphine, so you can do that switch. Hyoscine has been a real challenge in accessing...so we can move over to glycopyrronium. So, we can do that switch for patients and then it is seamless rather than if

you're asking GPs who aren't familiar with these drugs.' (Nurse prescriber 3)

At the service level, participants reflected on the strategic value of non-medical prescribers in planning and demonstrating measurable benefits. They recognised the importance of articulating outcomes to secure long-term sustainability and system buy-in and demonstrating to service managers that they are having a positive effect on care outcomes, with one commenting:

'There's got to be something around the deliverables as well, hasn't there? You know, if you enter into this, these are some of the outcomes that we would be expecting to see as well.' (Pharmacist prescriber)

Participants also identified the need to demonstrate the added value of NMP practice not only in care and service user outcomes but also in service efficiency:

'You've got to show that you're adding value in lots of different ways. We absolutely know that they're going to have an impact on patient care, but it's how they show that... how is it preventing admission? How is it keeping patients comfortable for longer? Show me how by prescribing you might not reduce spend on medicines, but you're going to reduce spend elsewhere. We're not ringing urgent care, we're not getting GP visits ...we need less DN [district nurse] visits.' (Pharmacist prescriber)

Non-medical prescribers were perceived by the participants as both clinically effective and economically beneficial, helping to prevent escalation of care, maintain service user stability, and reduce reliance on other external services. Participants also discussed how the impact of non-medical prescribers extended into wider interprofessional and interorganisational relationships. One participant described how collaborative working with a GP practice in a semi-rural area reduced workload and enhanced local service capacity:

'The GP practice was quite small, it was semi-rural and that means that if anybody needed anything from minor illnesses to minor injuries he [the GP] would have been called out on numerous occasions. I was aligned with his practice to do an extension.' (Nurse prescriber 4)

This collaboration was echoed by other participants who recognised the importance of non-medical prescribers demonstrating reciprocity and shared supervision, with one commenting:

'They're gonna be taking quite a lot of workload off GPs. So, they need to be acknowledging that and be facilitated to support their time.' (Pharmacist prescriber)

Participants also looked ahead to how these collaborative arrangements could support service development. The extension of prescribing roles into new contexts was seen as both feasible and desirable when built on existing partnerships, as one participant noted:

'I'm hoping to pick up with the frailty pharmacist and virtual wards pharmacist [and discuss] how we can extend prescribing into the care home setting.' (Pharmacist prescriber)

Across these accounts, participants positioned NMP as a vital connector between direct care provision, operational delivery and system improvement. Their insights reflected a growing recognition that the NMP role delivers measurable value: improving access to medicines, strengthening service efficiency, and fostering collaboration across organisational boundaries.

Constructing professional identity

Participants emphasised that being a prescriber extended far beyond the physical act of writing a prescription and involved a broader professional role that includes clinical reasoning, psychosocial education, and person-centred decision-making. One participant commented:

'The writing of a prescription and FP10 [prescription form] is the smallest element. It's about having an understanding of what you're prescribing, what the parameters are... but that's why we're really good at it, because we also provide that psychosocial education to patients and families.' (Nurse prescriber 3)

Participants recognised that qualifications alone do not define the boundaries of practice; prescribing activity depends on services aligning with professional standards, competence and confidence. Participants discussed how they negotiated these boundaries, declining prescribing when it fell outside their skillset or remit:

'For our own practice, I wouldn't prescribe anything what were uncomfortable with or feel unsure of.' (Nurse prescriber 1)

'Part of our work is governance process; we also wrote some principles of when we would prescribe and when we wouldn't.' (Nurse prescriber 3)

These comments demonstrate how participants' exercise professional judgement and embed governance processes within practice to ensure safety and accountability. One participant also described the importance of flexibility and not setting limited formularies, but instead supporting ongoing development to expand the scope of safe prescribing:

'It is in the interest of the nursing profession to, in a way, leave access open to the full formulary because every starting nurse prescriber will have a smaller scope.'
(Nurse prescriber 4)

Participants reported using both IP and SP to meet service used needs. Specifically, SP was identified as a mechanism for collaboration and shared expertise, enabling prescribers to work within their competence while contributing to complex decisions that they might not be able to manage independently:

'I think the supplementary prescribing has real power in the fact that you will have people who have their core competency, but supplementary prescribing allows – for example, in a care home working with other experts, say heart failure specialists – to titrate medications within a parameter.'
(Nurse prescriber 3)

Some participants reported that in social care, prescribing practice often involves deprescribing, requiring confidence and competence to safely remove medicines and optimise care delivery, with one commenting:

'There's massive traction in deprescribing.'
(Pharmacist prescriber)

This illustrates that professional identity in prescribing is both additive and reductive. Non-medical prescribers must discern when to start, adjust or stop therapy according to an individual's need, evidence and safety.

Alongside individual competence, participants reflected on the complexity of system-level responsibility. The multiple organisational affiliations of non-medical prescribers, across NHS trusts, ICBs, care homes and GP practices, created uncertainty around governance, accountability and indemnity – as one participant highlighted:

'The indemnity situation again, and who's going to do that? Who was taking responsibility for that, for us?'
(Nurse prescriber 1)

Participants also suggested that professional identity and visibility must be accompanied by participants' proactive role in advocacy, ownership and communication:

'We have to be more obvious... We have to be present... We're not a guinea pig.'
(Nurse prescriber 2)

While professional identity is an individual concept, it is inseparable from structural, organisational and system-level clarity. The ability to prescribe safely and confidently relies on both personal competence and coherent governance frameworks, demonstrating that the NMP identity is co-constructed across individual, service and system domains.

Preparing the path forward

Participants reflected on how the NMP role can remain relevant, viable and innovative through new models of funding, practice and professional development. Participants highlighted the pioneering nature of NMP outside traditional NHS services, recognising their own roles as innovators:

'What was really clear, what I didn't appreciate at the time when I started this journey, is that we were right at the spearhead of pushing the boundaries as a non-NHS provider.' (Nurse prescriber 3)

Much of the progress in NMP was reported to have come from local initiatives rather than centralised planning, with one participant noting:

'For me, I'm thinking, OK, what does that look like? Could our nurses in our homes be prescribers? Yes, they could. Is this something we would look at, an advanced role? Then what does that look like logistically?'
(Service manager)

Funding and budget allocation were highlighted as critical enablers or barriers. Participants noted that although broader system structures may support prescribing, local-level buy-in and financial commitment will be essential in the future:

'It's not a government blocker, but it's a much more primary care blocker because there's a funding element that they don't want to relinquish.' (Service manager)

Participants also reflected on the need to balance innovation with practical realities, including remuneration, governance, systemic support and the knock-on effect on service provision and business models. Delivering new types of prescribing services requires careful consideration of professional recognition and sustainable career pathways, as one participant explained:

'It's about collaboration and understanding that we would have to look at the contract because we'd be delivering a different type of service that requires a nurse being a prescriber. It's a higher-level qualification, and they would want to be remunerated for that. That's got to come from somewhere.' (Service manager)

As such, a consistent national framework for commissioning and governance was seen by one participant as a critical enabler to support innovation at scale:

'You need a national framework, don't you, for commissioning.' (Pharmacist prescriber)

The participants' discussions demonstrate that futureproofing NMP roles requires an integration of innovation, professional development and sustainable infrastructure

into a coherent, system-wide model. The sustainability and evolution of NMP depend on the interplay between innovation, strategic planning and systemic support. Participants recognised that they were pioneers who were pushing boundaries and emphasised the importance of building on these contributions. Together, these insights suggest that NMP roles have the potential to shape the future of prescribing practice, provided that innovation is supported by careful planning, governance and system-level alignment.

Discussion

As momentum builds around the English government's drive toward moving more care into the community and neighbourhood models, reducing avoidable hospital and care home admissions (DHSC 2025b, NHS England and DHSC 2026), caution is needed to ensure innovative changes to health and social care delivery is not solely focused on NHS outcomes and process. The King's Fund (2026) recommends that any moves towards a 'neighbourhood health service' must include careful consideration of shared budgets, joint decision making and shared accountability.

These recommendations resonate with the observations of the participants in this study, who indicated that the concept of 'home' requires reconceptualisation to encompass healthcare professionals working outside the NHS. These healthcare professionals need to be afforded the same connectivity, support and integration as their NHS or NHS-subcontracted counterparts. The DHSC (2025a) Adult Social Care Nurse Prescribing Pilot is one example of real-world innovation and reconceptualising of traditional care provision, celebrating and supporting nurses in social care settings to fulfil their professional and personal aspirations for career development.

However, research evaluating NMP in social care is limited. Existing studies, primarily based in UK care homes, include a randomised control trial (Holland et al 2023) and subsequent secondary analysis of data (Birt et al 2023), which focused on the feasibility of embedding independent pharmacist prescribers into care homes. The project aimed to improve pharmacological care while reducing GP workloads by introducing independent pharmacist prescribers not employed by the care home. However, several barriers limited the project's impact, including pharmacists' limited understanding of the care home context,

unclear role boundaries, and difficulties for the pharmacists in becoming socially and professionally integrated within the care homes and in general practice. Together with the analysis of this current study, these findings underscore the importance of prescribers being properly embedded within organisations, and how supporting nurse prescribing from 'in house' staff may mitigate barriers by involving the existing workforce rather than externally adding to it.

Birt et al (2023) also emphasised that the smooth introduction of prescribing into social care settings requires interdisciplinary and interorganisational collaboration, which would be best hosted by ICBs. This joined-up approach would support clarity around the scope of the role and prescriber expectations, and recognise that all prescribers practise within a single framework (Royal Pharmaceutical Society 2021) with competences specific to both the practitioner and the needs of the people they serve.

While there may be value in understanding common conditions and associated medicines, the findings of this study show that wholesale restriction of practitioners' scope of practice could be detrimental. The unique expertise of individual prescribers should be recognised, and existing frameworks already enable safe and effective expansion of individual scope of practice (Royal Pharmaceutical Society 2022). Hosting social care prescribing within ICBs may also support the development of resources, training and preparatory measures (such as digital access, supervision arrangements and opportunities for reflection).

Limitations

As a relatively small qualitative study, this project does not claim to be representative, or generalisable to the wider prescribing population.

Conclusion

Nurse prescribing in social care is poised for rapid expansion. While challenges exist, they stem primarily from organisational structures rather than individual nurses' practice. To enable effective implementation of NMP in social care, new models of integrated working that foster interorganisational connectivity and robust support, and establish the infrastructure required for effective service delivery are essential. Further research is needed to build a systematic understanding of how NMP can be embedded, sustained and evaluated within diverse social care settings.

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